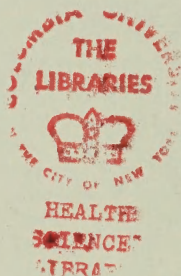


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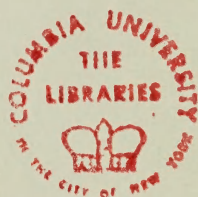
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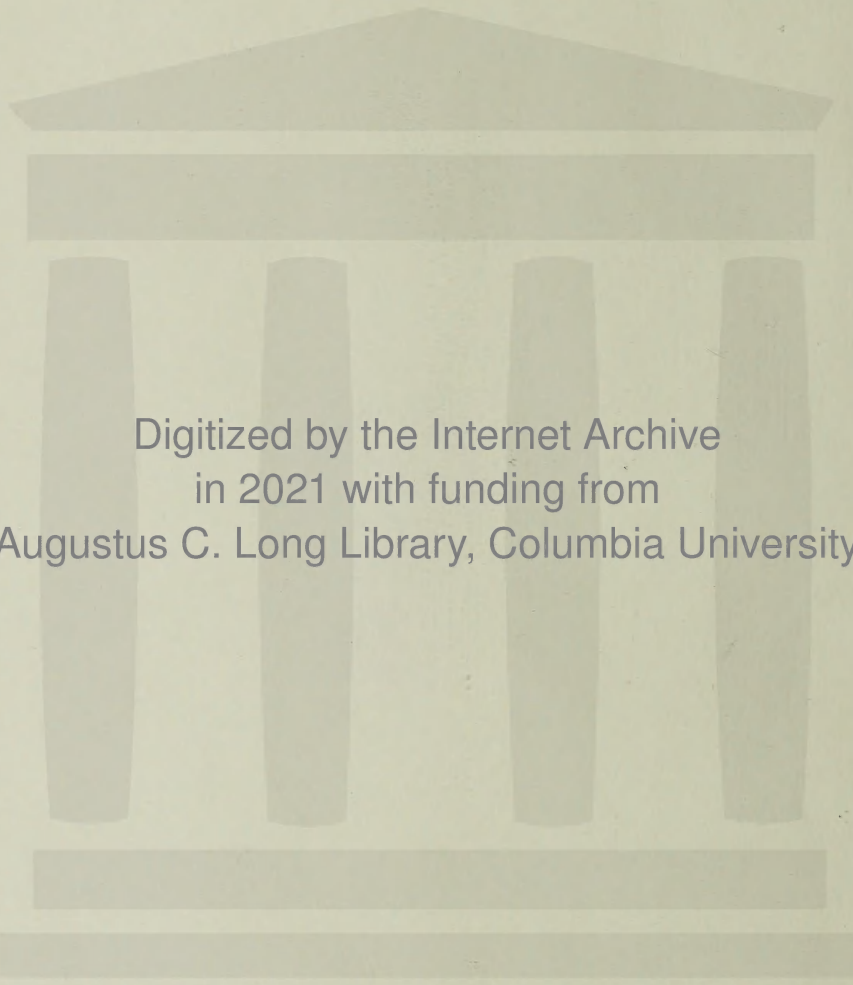




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VOLUME XLII, NO. 1

THE PRESBYTERIAN HOSPITAL AT COLUMBIA-PRESBYTERIAN MEDICAL CENTER

# Stethoscope



**NETWORKS:**  
CHANNELING  
HUMAN  
POTENTIAL



# Stethoscope

VOLUME XLII, NO. 1

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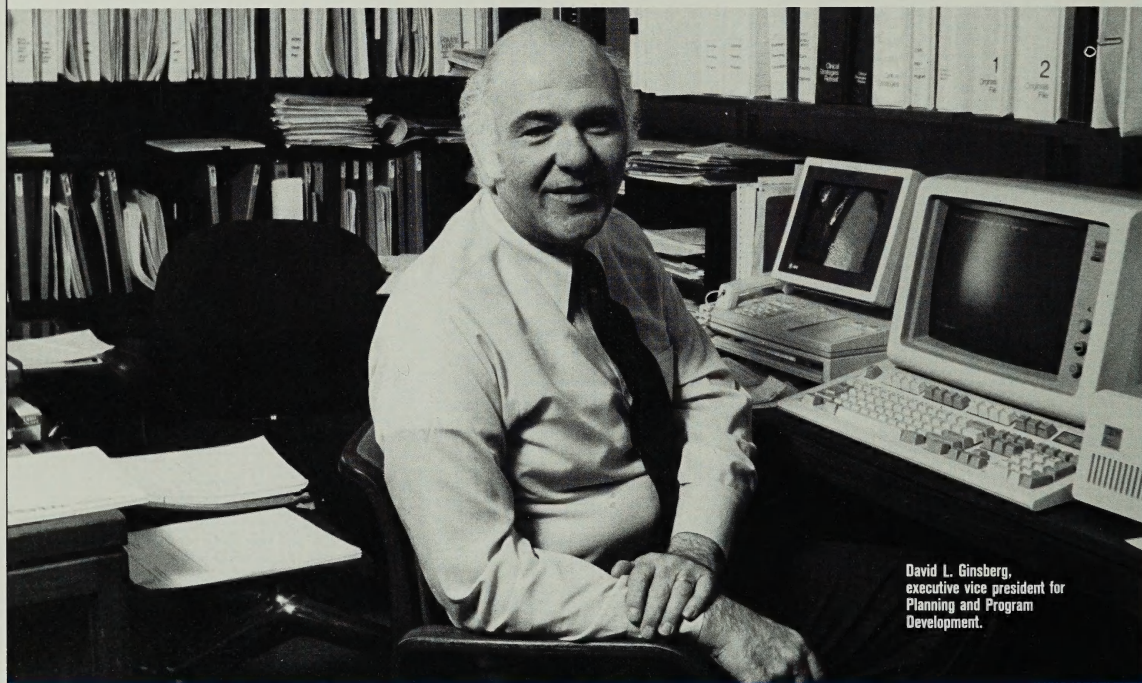


Within the Medical Center, in its own neighborhood, throughout New York City and far beyond, The Presbyterian Hospital is forging networks.

Presbyterian is taking the lead in decentralizing by establishing a community hospital in northern Manhattan and physician practices throughout the metropolitan area, including offices in several locations in the neighboring Washington Heights/Inwood community. At the same time, the Hospital remains part of a great Medical Center, and new technologies enable it to connect and interact with increasing numbers of physicians and patients throughout the world.



# THE MEDICAL CENTER OF THE FUTURE WILL BE A NETWORK



David L. Ginsberg,  
executive vice president for  
Planning and Program  
Development.

RENE PEREZ

"The medical center of the future will be a network." Underlying that seemingly simple statement, made by David L. Ginsberg in a recent interview, are complex changes already taking place at The Presbyterian Hospital and other leading health care organizations across the United States.

"Throughout its history, this Hospital has prided itself on being part of a geographically concentrated center that has all of the resources necessary to deal with a health problem," says Mr. Ginsberg, executive vice president for Planning and Program Development.

"In fact, it is the genius of this institution that it has a Babies Hospital, a Neurological Institute, a Cancer Center, heart transplantation and on and on."

Yet, in the past few years Presbyterian has begun major efforts at decentralization. It has established specialty practices on the east side of Manhattan and in Riverdale, and will be opening additional primary care facilities throughout the local Washington Heights/Inwood community. Presbyterian also is building a new community hospital, the Allen Pavilion, at the

northern tip of Manhattan. A new Resource Park, which will be in operation soon, will provide off-site support space.

Do these new facilities represent a radically new philosophy in health care delivery?

Not at all, says Mr. Ginsberg. "We're actually returning to an old model of health care where physicians' offices and their related hospitals were close to their patients. Why provide routine care in a highly specialized academic medical center? Why offer ambulatory care that requires a lower level of tech-

nology in a basically high-technology center? Why not let people walk to their physician's office if they can and tailor these programs more specifically to their needs?

"Furthermore, there generally is very little reason," says Mr. Ginsberg, "for patients needing services that can be successfully provided at other sites—routine maternity, primary pediatrics, general medicine, community dentistry and so on—to ever have to come to the Hospital unless they're really quite sick. In case hospitalization does become necessary, all of these patients would have access to Presbyterian, one of the world's most advanced, specialized care facilities."

While decentralization could be an unqualified success for patients, for health care providers it can be a mixed blessing. One may praise the potential increase in the efficiency of patient care at smaller off-site facilities; another may find the commute between an off-site location and the Medical Center inconvenient. Teaching is another difficulty: how does teaching take place in a decentralized model?

"These are problems, and also opportunities," says Mr. Ginsberg, "but if patient care is appropriate in these settings, we have to find ways to solve them."

Other off-site plans are embodied in the Ambulatory Care Network Corporation (ACNC). This program will "homestead" physicians at several sites throughout Washington Heights/Inwood, a medically underserved area.

"ACNC is quite different from East 61st Street and Riverdale, because of the people who will use it," Mr. Ginsberg says. "Here, clearly we are trying to create absolutely convenient sites for people who otherwise would have to come to the clinic or the emergency room to seek routine care."

The ACNC will deliver "continuous, comprehensive and responsive care," says Mr. Ginsberg. That means that patients will see the same doctor every time, or another doctor within the same group, and that they have access to primary care, family-oriented treatment in medicine, pediatrics, obstetrics, dentistry—"coordinated, quality health care," Mr. Ginsberg adds.

The Allen Pavilion, Presbyterian's community hospital now being built north of 218th Street and Broadway, is another example of decentralization (see sidebar). The new 300-bed facility will provide top-quality health care

## TOPPING OUT AT THE NEW ALLEN PAVILION



Progress in construction of Presbyterian's Allen Pavilion, New York City's first new voluntary hospital in over twenty years, was marked by a topping out ceremony recently. This was followed by a topping out of the new PH construction at Columbia-Presbyterian Medical Center.

The new 300-bed community hospital will provide quality health care to the more than 200,000 people who live in the more northerly parts of Manhattan—much of which has been designated as a medically underserved area and a health manpower shortage area—as well as residents of the neighboring Bronx areas.

"We wanted to show what could be accomplished when an internationally recognized academic medical center focuses its attention on providing high quality, cost-effective health care to the residents of its own community," said Dr. Morris. "The Allen Pavilion and ACNC, a related network of neighborhood physicians, are especially important in addressing the health care crisis affecting our communities."

Investment bankers Charles Allen,

Jr. and Herbert Allen made a joint gift of \$15 million toward construction of the Pavilion. The new hospital will be named in memory of their parents, Charles F. and Frances Allen.

The community hospital will include medical and surgical beds, four operating rooms, full imaging services, intensive/coronary care beds, a rehabilitation section, a psychiatry unit, obstetric services and a conference center. The grounds will be surrounded by terraced gardens, and many patients will enjoy river or garden views from their rooms.

The facility's services will address the special concerns of Washington Heights/Inwood, a community with a high percentage of elderly residents and a birth rate 75 percent higher than Manhattan as a whole. Capacity for over 2,000 routine deliveries with related support space has been provided in coordination with the high-risk maternity services of the main campus. A full-service emergency room is provided to coordinate with the primary care facilities of the ambulatory care network. ■



## PH Helps Establish VHA Metro NY, Also Joins 700-Member National Network

In December 1986, Presbyterian Hospital joined 11 other hospital organizations in the New York metropolitan area to form VHA Metro New York, the area's largest voluntary hospital system. The other organizations manage 17 hospitals located throughout the region, including the five boroughs, Long Island, and several upstate New York counties, representing more than 7,500 beds. The Hospital also became a shareholder in the national Voluntary Hospitals of America (VHA) network.

VHA was founded in 1977 to help selected not-for-profit hospitals and their medical staffs preserve quality health services and the stability and autonomy of each individual member. VHA selects hospitals according to strict criteria that include clinical excellence and management expertise. Each VHA regional system consists of leading community hospitals and major referral centers.

Nationwide, VHA's hospital system has more than 700 member not-for-profit hospitals throughout the United States. Both the national and regional

networks benefit member hospitals through integrated group purchasing, management information systems, joint business ventures, capital formation, marketing and communications, satellite videoconferencing and managed care programs.

"With the addition of Presbyterian Hospital," says Don L. Arnwine, VHA Chairman and Chief Executive Officer, "we can count Columbia-Presbyterian among the leading university medical centers that already are part of our national system." Other academic medical centers that are part of VHA include Johns Hopkins, New York-Cornell, Yale-New Haven, Massachusetts General Hospital, Barnes and Baylor.

The other VHA Metro New York members are: Bronx-Lebanon; Brooklyn-Caledonian; The Catholic Medical Center of Brooklyn and Queens; Mercy Hospital (Rockville Center); New Rochelle Hospital; New York Hospital; Northern Westchester (Mt. Kisco); St. Barnabas; Southampton; Church Charity Foundation of Long Island (Hempstead); and White Plains. ■

in the Inwood area. The Inwood and Washington Heights communities in northern Manhattan have lost five community hospitals, with a total of more than 1,000 beds closed over the past 20 years. The Allen Pavilion will help reverse those losses.

Moreover, says Mr. Ginsberg, "there is every indication that the Allen Pavilion will have a lower cost per bed." This is because many support services will be shared with the Medical Center, and because high-technology medical services such as neuroradiology will not be duplicated there.

The movement toward "managed care"—through Health Maintenance Organizations (HMOs) and Preferred Provider Organizations (PPOs) is enabling the Medical Center to further widen its referral networks. Some 500 CPMC physicians participate in such organizations. The Medical Center, one of six hospital partners in Maxicare NY, participates in Empire Blue Cross/Blue Shield Healthnet HMO, and may participate in several other HMOs and PPOs.

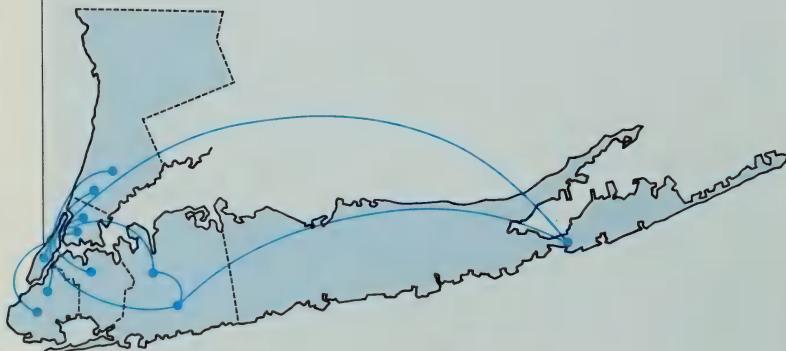
Most recently, Presbyterian has become a founding member, with 11 other hospital organizations, of a new regional network, VHA Metro New York. It is also one of the two metropolitan hospitals (the other is New York Hospital-Cornell Medical Center) to become a shareholder of Voluntary Hospitals of America (VHA), the national not-for-profit health care network. (See sidebar.)

Thomas Q. Morris, M.D., president of the Hospital, has called the VHA "an exciting opportunity for the participating hospitals to develop a true regional partnership.

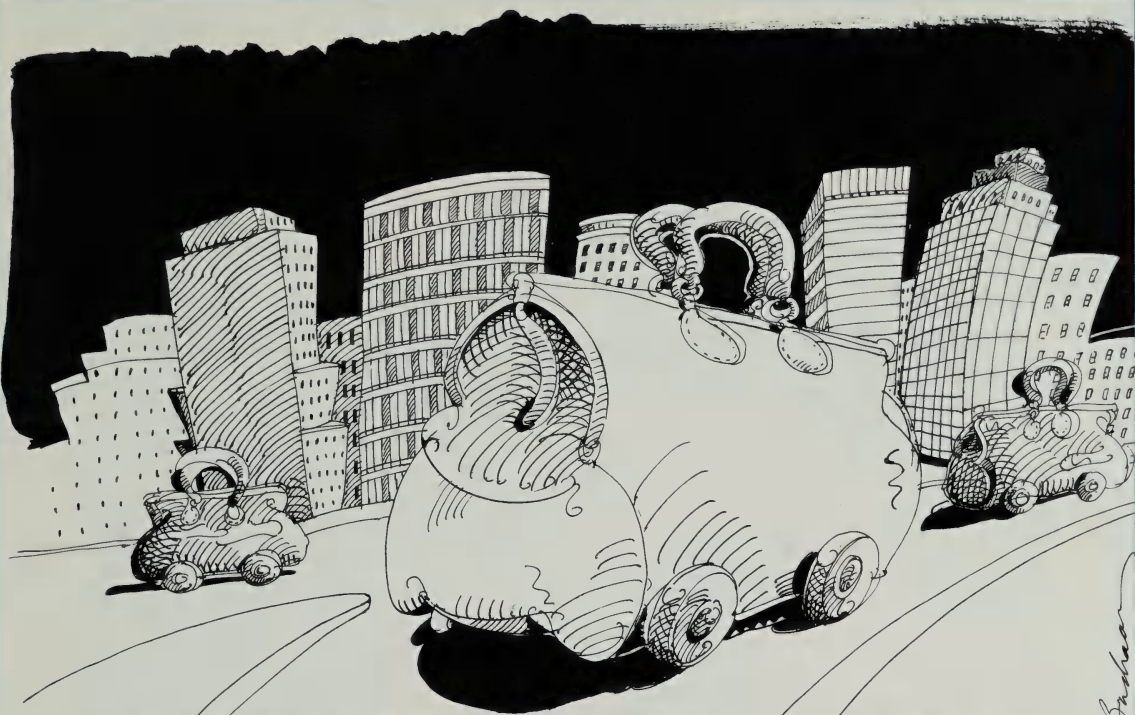
"To a large extent," Dr. Morris says, "the informal arrangements most voluntary hospitals have developed over the years were based on long-standing, personal relationships among the institutions and their doctors.

"Now, the VHA Metro New York system can supplement those valuable relationships with contractual, institutional affiliations among the partner hospitals, which cover a wide range of business ventures as well as potential patient service agreements.

"In addition, through the 700-member national VHA network, Presbyterian can work on cooperative programs with other academic medical centers such as Johns Hopkins, New York Hospital, Massachusetts General, Baylor, and Yale-New Haven, which also are VHA shareholders." ■







# “SHUTTLE DOCS”

## THE PROFESSIONALS BEHIND THE NETWORKS

In Riverdale, Dr. Harold E. Fox has just seen his last patient for the morning, a pregnant woman near term who is in for a routine check-up. Columbia-Presbyterian Riverdale Associates is a clinical practice whose location is convenient for patients who live in various areas of the Bronx, Inwood, Westchester and northern New Jersey.

Dr. Fox, associate attending at PH and associate professor of clinical obstetrics and gynecology and pediatrics at P&S, wraps up some last-minute paper work and sets out for the ten-minute ride to CPMC. There he plans to complete a grant proposal he's preparing and to review applicants for next year's crop of residents. He also wants to make sure the obstetrics floors are covered sufficiently to enable some of the residents to attend a March of Dimes conference about birth defects that's going on downtown. Dr. Fox at-

tended the opening dinner the previous evening.

But first, he takes a call from Yale-New Haven Medical Center. He is consulting specialists there about a pregnant woman whose fetal monitoring indicates a fetus with a cardiac defect.

"We are part of the National Network in Maternal-Fetal Medicine," says Dr. Mortimer G. Rosen. This network, sponsored by NIH, actually is a consortium of several academic medical centers, including PH/CPMC, Johns Hopkins, Yale-New Haven, University of Southern California, University of Tennessee-Memphis, and University of Pittsburgh-McGee.

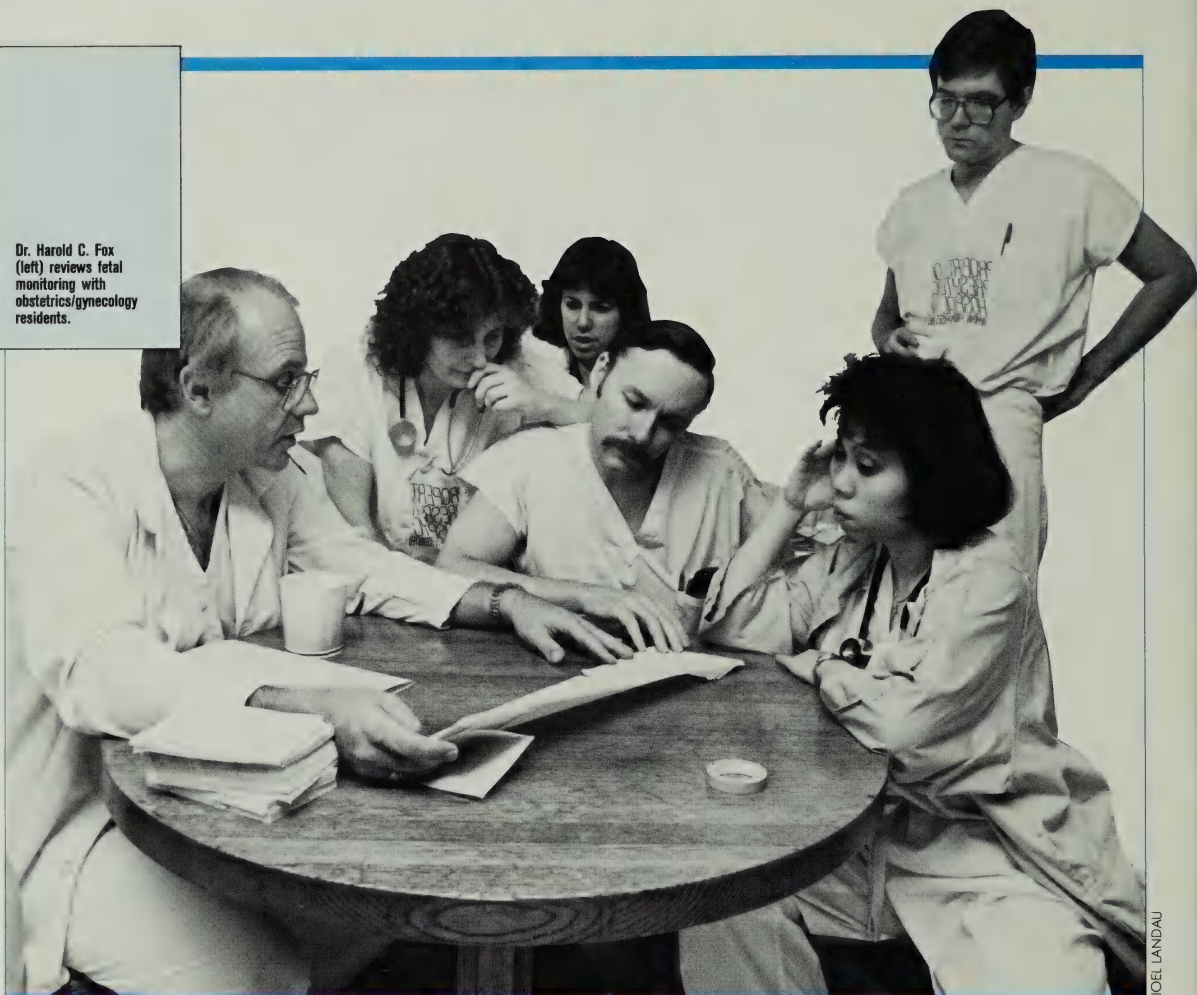
Dr. Rosen, director and chairman of obstetrics and gynecology, is principal investigator of a National Network collaborative research project to assess clinical care in obstetrics. Dr. Fox is also involved with that project.

### The Regional Perinatal Network

Another association, the Regional Perinatal Network, which Dr. Fox directs, enables hospitals in several counties throughout the New York metropolitan area to coordinate ob/gyn care. PH is the Network's regional center for tertiary perinatal care. This Network connects hospitals as close as Harlem Hospital and as far north and east as Good Samaritan Hospital in Rockland County and Stamford Hospital in Connecticut (see page 12). Physicians at affiliated Regional Perinatal Network hospitals identify mothers who are at risk and monitor fetal development to anticipate problems at birth. If necessary, they refer at-risk patients to PH/CPMC.

The Regional Perinatal Network has an especially important role as the number of obstetrics beds in the area is shrinking. "The west side of Manhat-

Dr. Harold C. Fox (left) reviews fetal monitoring with obstetrics/gynecology residents.



JOEL LANDAU

tan is feeling a real crunch," Dr. Fox says, "because several hospitals in the area have closed their obstetrics services."

Just as hospitals throughout the area and the nation work together to deliver the best care, so do services within the Hospital. For example, Mrs. Liu (not her real name), a woman of Chinese origin living in South America, was referred to Dr. Fox by physicians there. "She was 32 years old and suffered from lupus, an auto-immune disease," Dr. Fox says. "She'd had ten stillbirths and spontaneous losses, and when she came to us she was pregnant and very concerned about being able to deliver a healthy baby.

"Physicians throughout the Hospital cooperated in providing intensive care in rheumatology, medicine, pulmonary disease and maternal-fetal," Dr. Fox says. "She was delivered of the baby at about 32 weeks, and both she and

the baby—a girl—responded very well to treatments."

### The Midtown Connection

Dr. Lewis P. Schneider's roster of patients at Columbia-Presbyterian Medical Associates/Eastside include a Korean man in his mid-30s who is in New York on business, a psychiatric nurse, a man in his 60s accompanied by his wife, and a single man also in his 60s who has just returned from a vacation.

The Eastside practice, located on East 61st Street near Madison Avenue, offers services in dentistry, medicine, obstetrics and gynecology, dermatology, otolaryngology, urology, radiology, psychiatry and other fields. Several special-interest groups that focus on weight disorders, smoking cessation, cocaine abuse and stress meet during daytime and evening

hours. There are also programs in adolescent and geriatric medicine. While patients at East 61st Street represent New York's diverse population, many are from nearby communities.

Stress can contribute to many gastrointestinal disorders, and some of the questions Dr. Schneider asks each patient relate not only to diet but to particular problems they may be having. For example, he has treated the psychiatric nurse for an ulcer, and he knows that her difficult job and problems with her son have most likely exacerbated her abdominal distress. He asks about her present situation and then examines her.

### Encouraging Outpatient Care

After hours are complete at 5 p.m., Dr. Schneider drives uptown to PH/CPMC. There he conducts



Dr. Lewis P. Schneider at Columbia-Presbyterian Medical Associates/Eastside.



rounds, and spends extra time with a man in his late 60s who had a malignant tumor in his esophagus. The local tumor is gone, but the man is dying from distant spread. He has limited means and Dr. Schneider is concerned about what he'll do when he is ready to leave the hospital. "He wants to go home, but I think he knows that his wife can't take care of him very well. I want him to consider a hospice."

Dr. Schneider is an expert in using fiber and laser optics to treat gastrointestinal disorders. He is able to perform many procedures on an outpatient basis, both at PH/CPMC and East 61st Street.

"To me, any time a person is hospitalized who could possibly be treated on an outpatient basis, that is a misuse of hospital facilities," he says. "I try to do as much as possible on an outpatient basis."

### Restructuring Teaching Methods

In a teaching hospital, briefer hospital stays and increased numbers of outpatient procedures can cause special problems. "We used to rely on having patients in the hospital for several weeks, so that staff could study their progress," Carolyn Britton, M.D., says. Dr. Britton is assistant attending at PH and assistant professor of neurology at P&S, and director of the Hospital's neurology clinic.

"Now most patients don't need to be hospitalized. We are planning an ambulatory care facility that will fuse our clinic with the doctors' offices to create an 'integrated ambulatory care unit,'" she says. "We'll use this unit for teaching as well as patient care."

Of course, some patients have to be hospitalized. Dr. Britton recently treated a patient from Barbados, who was here with her husband, a

prominent political leader from that island. "A colleague referred her to me," Dr. Britton says. "As soon as she walked in I suspected an adrenal tumor, and that turned out to be what it was."

"She was terrified before the operation," Dr. Britton says, "and so was her husband. I got them both together for a pep talk before we began. 'I can't have you going into this operation thinking you're going to die,' I told her. And sure enough, the operation went very well and she's fine now."

Dr. Britton specializes in diagnosing and treating infectious diseases that affect the central nervous system. She was one of the first to recognize that certain neurological disorders are symptoms of AIDS, and has written extensively on that disease. She is a faculty adviser to the Black and Latin Students Association at P&S and is active with the Susan Smith McKin-

Dr. Carolyn C. Britton administering a neurological test at Columbia-Presbyterian Medical Associates/Eastside.



ney Stewart Association, a group that provides support and outreach to black women who are medical students and residents in the metropolitan area.

### **Catching the Shuttle**

A couple of times a week, Jack Wazen, M.D., director of neurology at Presbyterian, can be seen hurrying out of Atchley Pavilion to catch the shuttle van to East 61st Street. Today, the Friday after Thanksgiving, he is supervising residents in Vanderbilt Clinic. So far he's seen a young woman with a routine ear infection and an older woman who has returned for a check-up after being treated for a severe infection.

The unusually quiet day gives him a chance to examine a tray of slides to illustrate a talk he'll give on pediatric otologic surgery at the New York Academy of Medicine. Dr. Wazen teaches a

course on the pathology of the auditory system to speech pathology and audiology students at Columbia University's affiliate, Teachers College, and gives a course on intraoperative monitoring at the annual meetings of the American Academy of Otolaryngology. In addition, he conducts research on intraoperative monitoring.

### **An Unusual Referral**

Just as the clinic is about to close, a five-year-old girl who was born with no ears comes in; she's been referred to Dr. Wazen from one of the largest hospitals in the city. The problem is unusual and the little girl sits patiently as Dr. Wazen and several residents examine her.

Her physicians have fitted her with a bone conduction hearing aid. "Because she has no ear, she has no opening into the inner ear," Dr. Wazen ex-

plains. "This kind of hearing aid works as a bone vibrator that conducts sound directly into the inner ear through the skull."

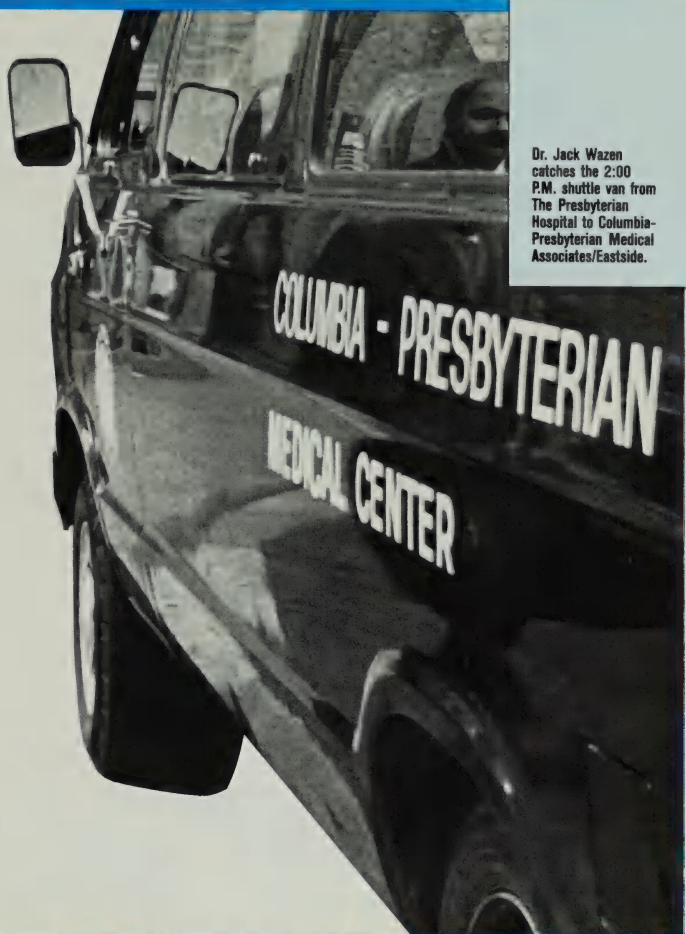
Dr. Wazen feels that the youngster will benefit from an operation that will virtually create an external auditory canal and a middle ear cavity, allowing the sound waves to reach the inner ear. This, combined with plastic surgery to create an outer ear, will provide the patient with a functional and cosmetically acceptable ear. But her family may decide to wait until the youngster is old enough to decide for herself about whether to have the operation.

### **Treating Severe Vertigo**

Dr. Wazen's specialty is treatment of severe vertigo, a debilitating disease that causes dizziness and vomiting. Dr. Wazen perfected an operation at PH that can alleviate symptoms of vertigo.



Dr. Jack Wazen catches the 2:00 P.M. shuttle van from The Presbyterian Hospital to Columbia-Presbyterian Medical Associates/Eastside.



One of his patients, Judi Weintraub, recently underwent the five-hour procedure.

"I read about Dr. Wazen in an article in *New York Magazine*," says Ms. Weintraub, a resident of Long Island. "I'd been all over for treatment, and I really was desperate. I came to see Dr. Wazen and six months later agreed to the operation."

According to Dr. Wazen, surgical techniques previously available to treat persistent vertigo either were not sufficiently effective or involved hearing loss or were excessively dangerous. Dr. Wazen's procedure can effectively and safely cure vertigo without sacrificing hearing. It combines microsurgical techniques, a computerized monitoring system and a new surgical approach.

A single nerve bundle that leads from the inner ear to the brain is comprised of the nerve fibers responsible for equilibrium and those

responsible for hearing. If this nerve is cut, vertigo disappears, but so does the hearing. Although the fibers in this nerve are no thicker than pieces of thread and virtually indistinguishable from each other, Dr. Wazen is able to cut only the fibers responsible for the vertigo.

"In order to monitor the patient's hearing under general anesthesia," Dr. Wazen explains, "we apply electrodes to measure electrical activity traveling through the nerve in response to the auditory stimulus. This helps avoid injury to the auditory nerve and minimizes post-operative hearing loss."

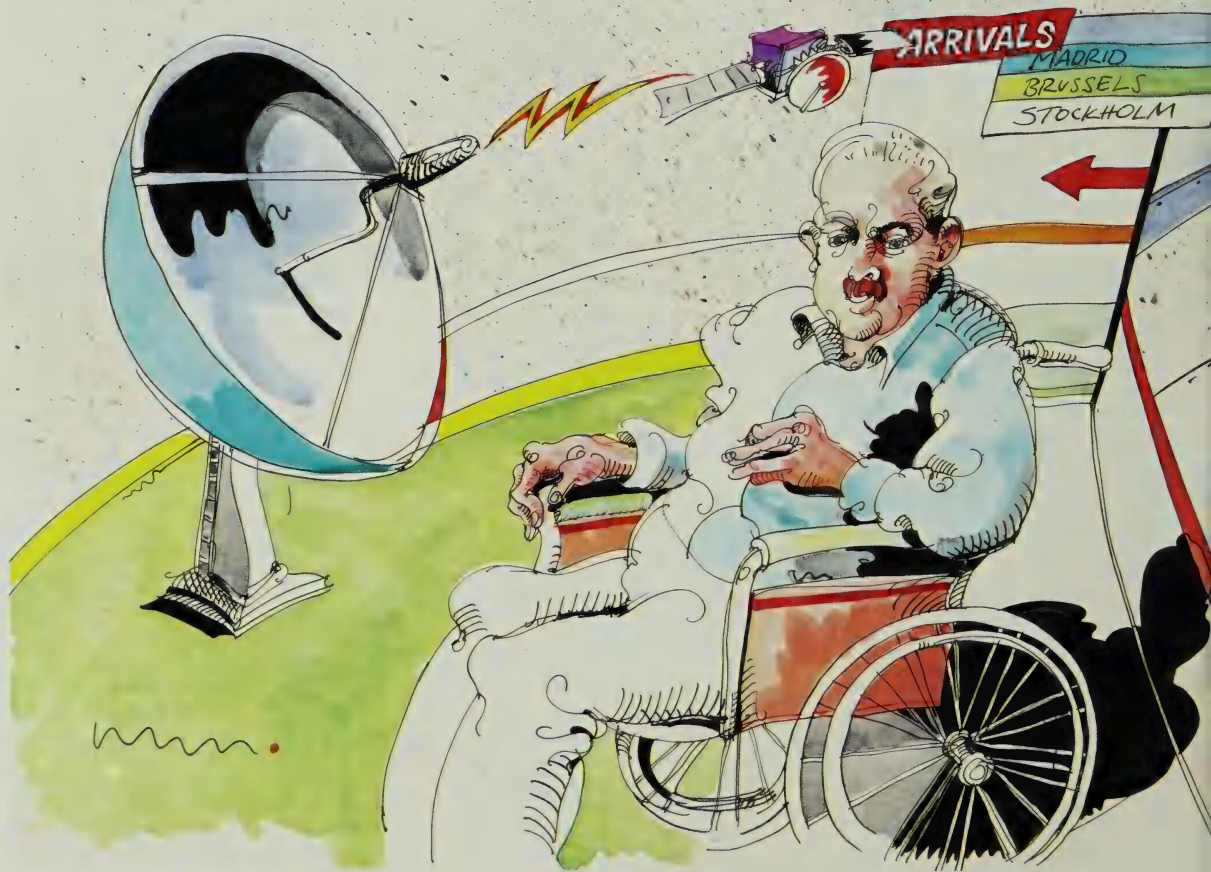
An operating microscope with two eyepieces allows Dr. Wazen and residents to work with precision, and a computerized monitoring system, called evoked auditory potentials monitoring, protects the auditory nerve during the operation.

A microphone emitting a series of

clicks is placed in the patient's ear to stimulate the auditory nerve, and an electrode placed on the nerve picks up the impulses as they travel to the brain. A minicomputer plots this information on a screen which is continuously monitored during surgery. If the graph changes significantly during a procedure, the surgeon knows that he is disturbing the nerve fibers responsible for hearing and must leave them alone. Full recovery from the operation takes from six to eight weeks.

Through professional organizations, research and training, Drs. Fox, Schneider, Britton and Wazen, together with their colleagues, create networks that radiate from PH/CPMC to every part of the nation and the world, and that bring the larger world to the Medical Center. Most importantly, their work translates into outstanding medical care. ■

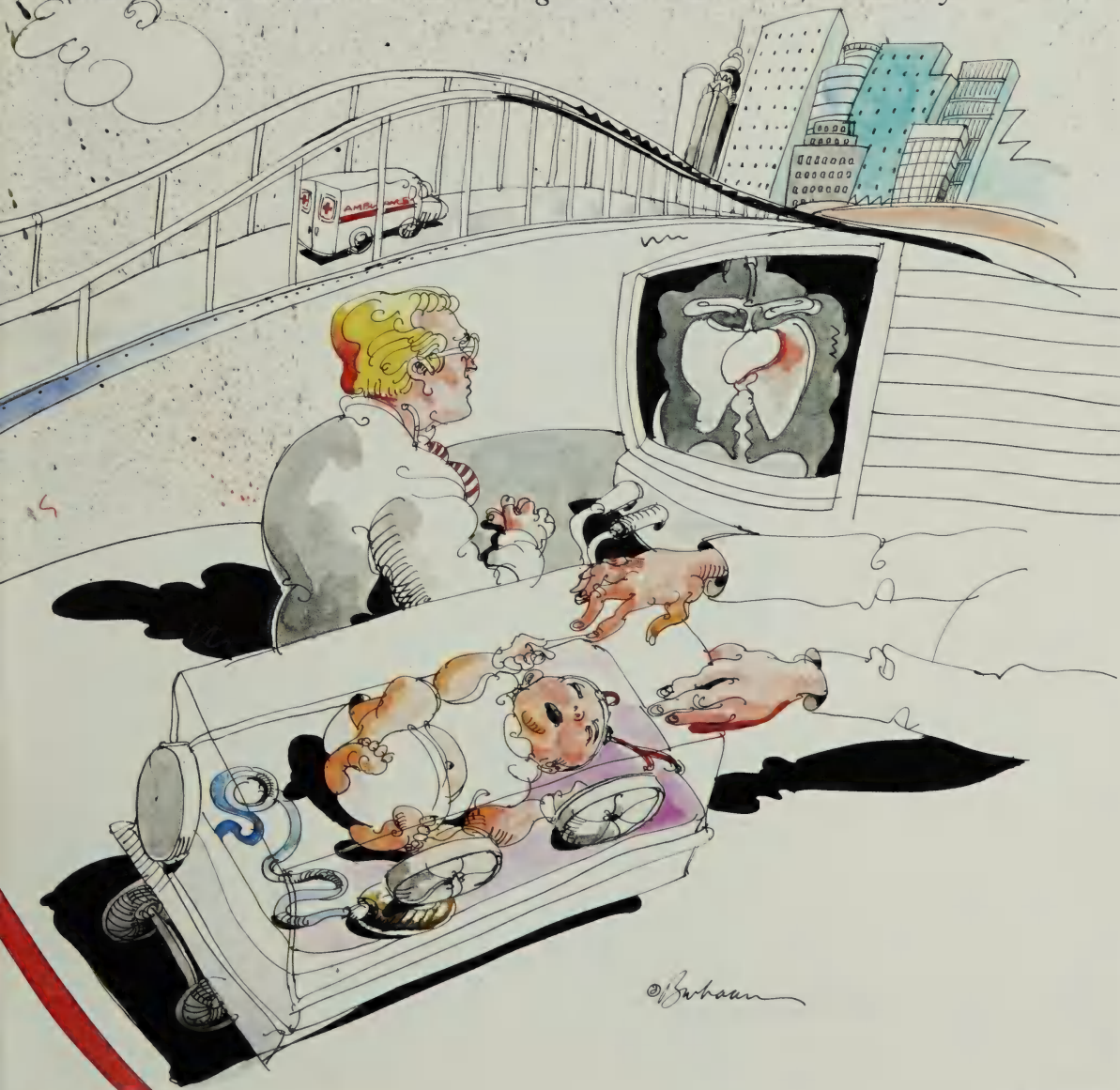
# ACROSS THE NATION AND AROUND THE WORLD





Every day, hundreds of physicians, researchers and patients from around the world consult with specialists at The Presbyterian Hospital/CPMC. Formal and informal conferences are conducted by letter and telephone, as well as using state-of-the-art computer and video technology.

The clinical programs associated with CPMC's Comprehensive Cancer Center, Comprehensive Sickle Cell Center, new Salivary Gland Center and Parkinson's Disease Foundation are only a few of the many PH/CPMC programs that serve as clearinghouses for information, research and development of innovative treatments. Each has a vital role in advancing research and health care delivery. ▶



### **Delivering Care to Newborns**

A small room in the neonatal unit of Babies Hospital is dimly lit; it's midnight, and because even a six-day-old baby responds to time changes, the staff tries to simulate day and night conditions as closely as possible.

The baby girl is being treated by ECMO, short for extracorporeal membrane oxygenation. At birth, she had a grossly malformed lung which had to be removed. At the time, her remaining lung was functioning inadequately for her to sustain life.

ECMO saved her life. ECMO works by taking over for her one lung, supplying oxygen to her blood and letting the heart rest until the lung is developed enough to work on its own, a process that usually takes between a week and 10 days. Catheters carry blood from the baby's heart through the oxygenating mechanisms and back to the heart.

"We've been working with this baby for 160 hours," says Charles J. Stolar, M.D., a pediatric surgeon and director of the ECMO program. "She's just about ready to come off ECMO, probably in another seven hours." The staff, including senior research associates Peter Dillon, M.D., and Cynthia Reyes, M.D., and nurse Inez Terry, R.N., constantly check electronic monitors that are part of ECMO for blood pressure, the amount of oxygen in the blood, IV fluid volume and other vital information.

Once the baby is weaned from ECMO, she will be in the Hospital for about a month, according to Dr. Stolar, who, with Drs. Dillon and Reyes, created the ECMO program at the Babies Hospital division of PH.

"We had our first ECMO patient in December 1983," Dr. Stolar says, "and so far tests show that 70 percent of the kids are normal. Most of the others show some relatively minor motion impairment.

"ECMO is a heroic last measure to save the baby's life," Dr. Stolar says. Babies Hospital is one of only three hospitals in the northeast to have ECMO, and the only one in the tri-state area. These babies come from the entire metropolitan area, including upstate New York, Connecticut, New Jersey, Pennsylvania, and as far away as Maine. "There are ECMO units in Boston and Washington, D.C., and if one is busy we help each other out," Dr. Stolar says.

Often, patients are referred to Dr.

Stolar from hospitals in the Regional Perinatal Network. When Corinne Kleinman was born at a Rockland County Hospital, she was fine for a few hours, but suddenly she developed a breathing problem and turned blue.

The attending pediatrician thoroughly evaluated the infant and discovered that it had developed a significant breathing impairment. A decision was made to call Presbyterian to arrange for ECMO. Corinne was rushed to Babies Hospital by ambulance and immediately put on the ECMO device. Corinne remained on ECMO for about a week.

The Kleinmans brought Corinne back to PH in January for follow-up checks. "We saw a neurologist, a heart and lung specialist, a plastic surgeon, and Dr. Stolar," Mrs. Lyane Kleinman says. "We were exhausted, but Corinne's doing fine—we're very happy."

The Regional Perinatal Network coordinates health care for newborns and critically ill pregnant women among 10 member hospitals: Harlem, St. Luke's/Roosevelt and St. Vincent's in New York; Good Samaritan and Keller Army Hospital at West Point in upstate New York; Morristown and Overlook in New Jersey; and Stamford in Connecticut.

In addition to patient care, the Network coordinates joint research projects among member hospitals and sponsors continuing education workshops for physicians, nurses and social workers.

"Workshop participants and speakers come from several different areas, including pediatric surgery, neonatology, anesthesiology and obstetrics," says Margherita Modica Hawkins, R.N., M.S., director of education for the Network. The interchange of disciplines is very stimulating and helpful in day-to-day work."

Dr. Fox explains that the Network is based on the idea that community hospitals can offer less intensive levels of care if they are tied to a major referral center. Middle level hospitals provide care for most patients, including those at risk.

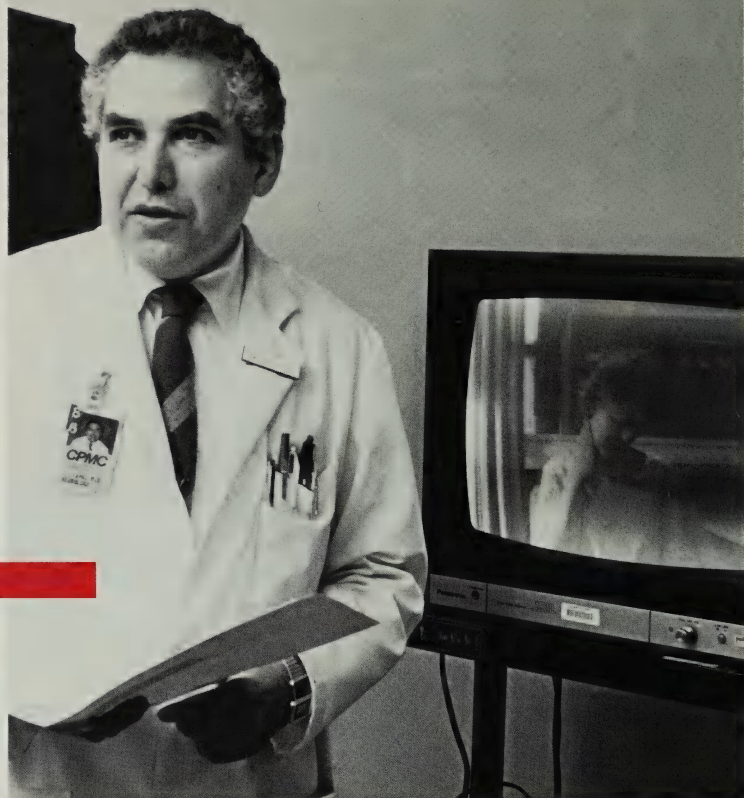
Level III hospitals, such as Presbyterian, provide care for both normal and high-risk patients, and specialize in caring for the most difficult maternal-fetal and neonatal cases. Level III facilities coordinate referrals from member hospitals. "We treat patients from Network affiliates as if they had always been registered under our care," Dr. Fox says.





Dr. Charles Stoia  
checks a meter on  
ECMO equipment.

Dr. Stanley Fahn analyzes a patient's movement disorders during video rounds.



### Neurological Diagnoses From Afar: Video Rounds

Advanced technologies such as videotape are enabling physicians to create networks that could not have existed before. Neurological Institute's video rounds are an example.

Stanley Fahn, M.D., attending neurologist at PH/CPMC and Merritt Professor of Neurology at P&S, is a specialist in movement disorders. Thanks to video, it no longer is necessary for patients to be present in order for Dr. Fahn and his group to make difficult diagnoses.

"Most of the videos are of patients at the Neurological Institute," says Dr. Fahn, "but we do get tapes from physicians at other hospitals, including some literally across the country. In those cases, we analyze the videos and write up our analyses in a letter to the referring physician. So the patient no longer physically has to be here for us to suggest a diagnosis and treatment strategy."

During a recent conference, Dr. Fahn and his group viewed the first edition of the *Movement Disorders*

video medical journal, which Dr. Fahn co-edits with Professor C. David Marsden of London. The new journal, which consists of a standard written section accompanied by an illustrative videotape, enables subscribers to actually see cases being discussed.

"In movement disorder cases, a written description just isn't enough," Dr. Fahn says. "The video journal will help physicians in diagnosing movement disorders by letting them actually see the problem."

Dr. Fahn specializes in diagnosing and treating all types of movement disorders, including dystonia, a relatively rare disease. "Many physicians may never have seen it," he says, "and they may not even recognize it." His group of Fellows always includes several from foreign countries. Recent Fellows have come from Spain, Poland, England, Italy and China.

The use of video and other technologies has had a profound effect on the treatment of disease. In the case of dystonia, symptoms have frequently been mistaken for hysteria or other types of movement disorders. There are

tragic cases of dystonia sufferers being committed to mental hospitals, sometimes for years, instead of being treated for the correct disease, according to Dr. Fahn. The tragedy is magnified because it is a disease that can be treated successfully in more than 50 percent of cases.

"And even for the others," Dr. Fahn says, "it makes a difference to them that someone recognizes their disease and is willing to work with them. It makes all the difference for them to know they're not alone." Video rounds and the *Movement Disorders* video journal will help make that difference for increased numbers of people.

### Helping People Referred to the Center

While new technologies are allowing many patients to benefit from the expertise of specialists at Presbyterian even though they are miles from the Medical Center, many patients do travel great distances to be treated here. Recently a little girl from a remote village in Nigeria was flown here for plastic surgery.

Adiaha, who is being raised by her grandmother, was ostracized in her village because of her appearance. She was born with a rare birth defect, an oroocular cleft, that deformed her face. The cleft, a fissure in her gums and skull, ran along the side of the nose to the inside corner of the eye, contorting her lip, nose and corner of her eye.

Michael Stalneck, M.D., director of pediatric plastic and reconstructive surgery at PH, evaluated Adiaha and decided to operate on her. He said that an oroocular cleft occurs once in

75,000 births, in contrast to the more common cleft lip and palate, which occur once in 700 births.

The four-hour operation, performed by Dr. Stalneck, was successful and gave her a chance at a normal life.

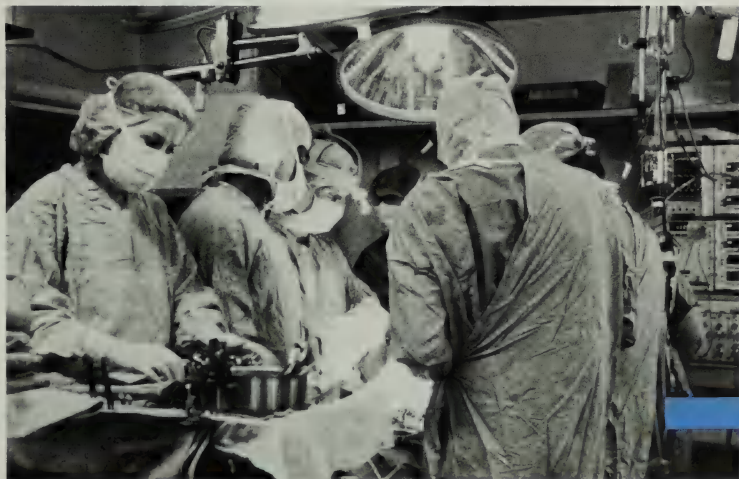
"Without this surgery, Adiaha might have been an outcast for the rest of her life," he says. "I am hopeful that now she'll be able to lead a more normal existence when she returns to her village."

### Organ Transplants Depend on Networks

Organ transplantation is a treatment of last resort, ordered when the patient has no other hope. It involves great risk, both because of the operation itself and because of the possibility that the patient will reject the donated organ, but risks are being sharply reduced by new technologies, according to Keith Reemtsma, M.D., director of surgery at PH and Valentine Mott Professor, Johnson and Johnson Distinguished Professor and Chairman of the Surgery Department at P&S.

An organ transplant is really an operation within an operation. First, a donor must be identified and his or her heart, lung or kidney retrieved safely and rapidly. That operation must be synchronized with the process of getting the recipient to the Hospital and preparing him or her to receive the donor organ.

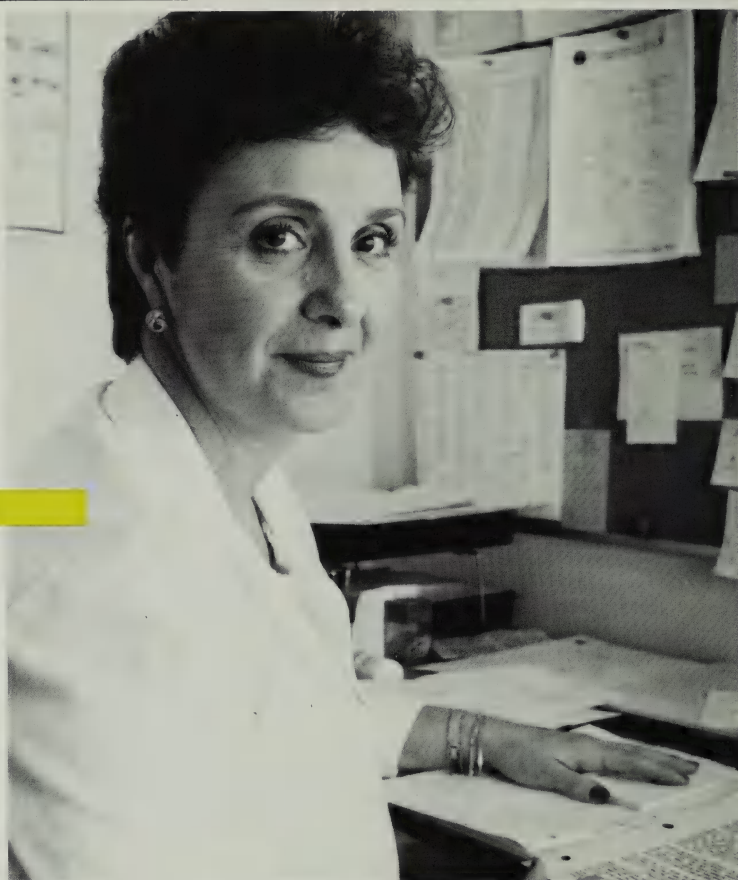
The severe scarcity of donor organs further complicates an already complex process. "Without networks, arranging organ retrievals would be close to impossible," says John Kiernan, administrator and coordinator of organ recovery at PH.



Heart transplant operation.



Judy Cianci,  
coordinator, kidney  
transplant program.



Presbyterian is affiliated with several networks that coordinate transplants, including the New York Regional Transplant Program (RTP) and the United Network for Organ Sharing (UNOS). UNOS recently has been awarded a Federal contract to develop an Organ Procurement and Transplantation Network (OPTN), according to Mr. Kiernan. OPTN will maintain a national registry of transplantation patient candidates, including those waiting at PH, to facilitate organ sharing. It will also collect and monitor data concerning the transplantation process.

"RTP is a conduit for donor kidneys," says Judy Cianci, R.N., coordinator of Presbyterian's kidney transplant program. "Many donor kidneys come from hospitals in the five boroughs, New Jersey, and the upstate counties that are closest to New York City," Ms. Cianci says. However, during the past several years, more than 60 percent of post-mortem kidneys transplanted at PH have come from

other parts of the country, according to Mr. Kiernan.

Heart transplants present a special problem because donors are rare and some patients die waiting for a new heart. Presbyterian sends its own team to retrieve the donor heart, to ensure that it is compatible and not damaged.

"Most hearts come from outside the city and may be from anywhere on the Eastern seaboard, including Canada," says Joann Lamb, R.N., coordinator of the heart transplant program at PH. "Our team flies to New York with the heart, and an ambulance meets them at the airport and speeds back to Presbyterian." As liaison for the retrieval team, the PH operating room staff and the patient and patient's family, Ms. Lamb sees that every phase of the procedure is fully synchronized.

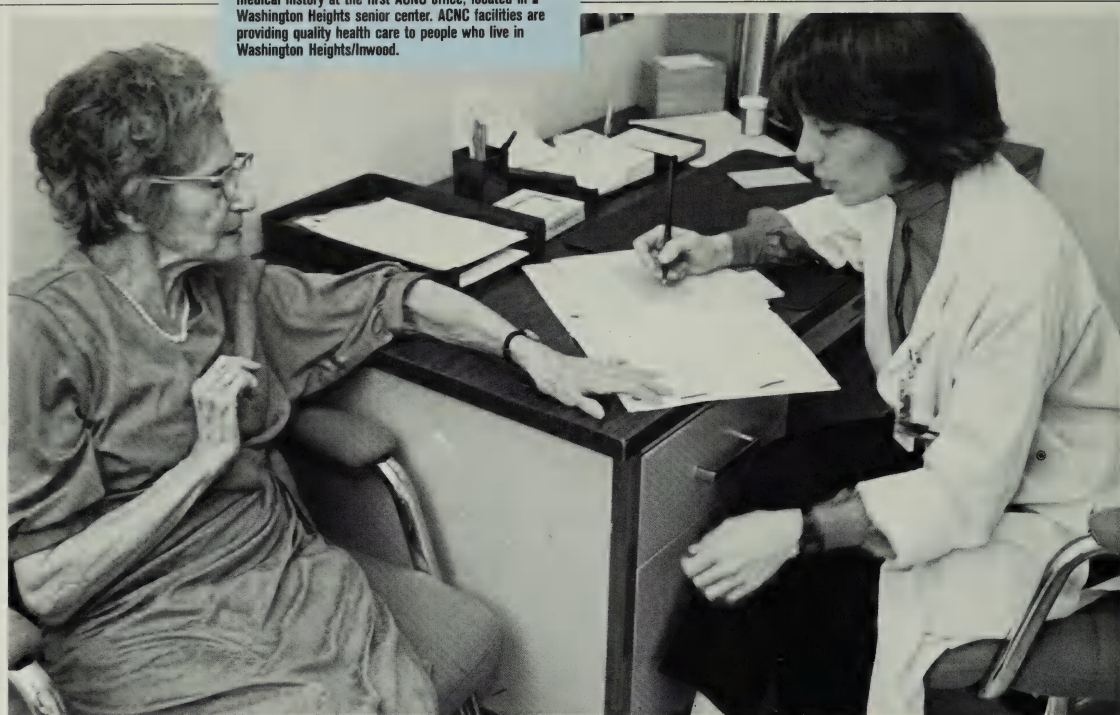
Through these kinds of networks, PH/CPMC interacts with hospitals, physicians and academic and medical centers everywhere to enhance every aspect of health care, training and research. ■

# CREATING NETWORKS CLOSE TO HOME

For a community to be "healthy" in every sense of the word, it needs more than a hospital with the latest diagnostic and treatment facilities. It needs physicians in private practice, special clinics, programs for the poor and elderly, and increasingly, programs for the homeless and mentally ill. That's especially true for an inner-city neighborhood such as Washington Heights/Inwood, whose ▶



Linda Dillman, a nurse practitioner, reviews a patient's medical history at the first ACNC office, located in a Washington Heights senior center. ACNC facilities are providing quality health care to people who live in Washington Heights/Inwood.



ethnically, socially and economically diverse character places unusual demands on the health care system.

The Presbyterian Hospital is, of course, known worldwide as a provider of specialized care. But it also has become the community's major primary care provider and, accordingly, has developed various local health care networks that address the neighborhood's wide-ranging health care needs.

One example of Presbyterian's local health care approach is the Hispanic Psychiatry Clinic, whose staff, importantly, is fully bilingual. Bilingual ability is important because clear communication is key to effective psychiatric therapy. "With many specialties, problems can often be handled in translation," says Rafael Tavares, M.D., director of the clinic and the Hospital's Community Psychiatry Program. "In psychiatry, where communication is so critical, there has to be a direct line of understanding. Translation will not work."

The large population of young immigrants in the neighborhood creates many problems, such as adapting to a new culture and language. Dr. Tavares, who was born in the Dominican Republic and raised and educated in Washington Heights, brings an insider's perspective to such issues.

"We see a lot of problems with inter-generational communication," Dr. Tavares says. "Parents have values from their homeland, but kids grow up with the values of this country as well. Many of the people on our staff have come from similar backgrounds and are very familiar with these kinds of conflicts."

"Most of our patients are women, and many are single heads of household," Dr. Tavares continues. "That means that we're not helping many of the men in this community, and we want to work on reaching them."

Dr. Tavares also is involved with the Hispanic Health Initiative, a network that connects the Medical Center with the Universidad Autonoma de Santo Domingo in the Dominican Republic, where a major conference on health needs of Dominicans is being planned for late this year. CPMC staff and Universidad administrators and faculty are planning the conference jointly.

In addition, the Hispanic Health Initiative is developing an exchange program between the two institutions. This academic year, a graduate student from the School of Public Health is conducting field work in Santo Domingo, and the School is actively encouraging Dominican students to apply to CPMC schools.

## Community Relations

Community relations have become especially important since the Hospital began its construction and expansion program at the Medical Center and Baker Field. Many community leaders are meeting with Hospital administrators to design new Hospital programs and services that will be responsive to the needs of local residents.

One local group, the Washington Heights/Inwood Council on the Aging, already is actively involved with Hospital social workers and health educators as well as many CPMC administrators and physicians. "Without Presbyterian and the Isabella Geriatric Center [another major local health care provider], the Council just couldn't be as strong as it is," says Council co-chair Leslie Foster.

This cooperation is evidenced in the work of the Hospital's Mobile Geriatric Outreach Team, says Ruth Rossini, co-chair of the council, who works at the local STAR (Seniors Together for Action and Recreation) Senior Center. "Recently, two sisters, ages 75 and 78, who come to the center and are normally very lively and cheerful, began to have problems," says Ms. Rossini. It turned out that their brother recently lost his wife and became extremely depressed. He came to stay with the



sisters temporarily but he wound up living there permanently.

"He wouldn't dress or feed himself, developed a tremor that looked like Parkinson's Disease and became very ornery," Ms. Rossini says. "It was really getting to the sisters, to the point where they became depressed, too."

"The Mobile Team visited the sisters at home and referred the brother to a doctor at Presbyterian to help with the Parkinson's. They did crisis intervention with the sisters to get them to see that they weren't responsible for their brother's problems. He's still there and he's still ornery, but they're dealing with him in a healthy way and feeling better themselves."

### Educating Seniors

An aging population has many mental and physical health problems, so health education is critical for them. According to Socorro Rosado, who coordinates the Hospital's health education and promotion programs for Washington Heights/Inwood's ten sen-

ior centers, "many of the senior citizens in our program have chronic diseases that require special diets, exercises and possibly medications. I find that the ones who do not follow doctors' orders generally are low in self-esteem and self-image."

Ms. Rosado arranges workshops on topics such as arthritis, diabetes, hypertension, weight loss, decreased blood pressure, depression, loneliness, dental care, sexuality, forgetfulness and nutrition. The workshops are led by Hospital staff. She also teaches nutrition to senior center cooks, and coordinates programs in basic lifesaving and cardiopulmonary resuscitation (CPR) for all center staff.

Ms. Rosado's work extends beyond the Hospital and senior centers to include collaboration with organizations such as the Lighthouse for the Blind, which helps vision-impaired seniors in cooperation with Hospital ophthalmologists. She also refers seniors to PH/CPMC programs such as the Memory Disorders Center.

### The Return of Private Practitioners

At a time when Washington Heights/Inwood needs more doctors, it has been losing them steadily. There now is only one physician for every 840 residents in the growing community of Washington Heights/Inwood. Normal attrition through retirement, relocation and death are among the factors that have dramatically reduced the numbers of local physicians. This in turn has been compounded by the effects of population shifts and the limited financial resources of many residents. Those with Medicaid coverage may have a hard time finding a physician, since reimbursement rates are low. Others, whose incomes are limited but not low enough to be covered by Medicaid, often are unable to pay for physician services at all.

Thus, many community residents rely heavily on the Hospital's clinics, group practices and emergency room. In response, Hospital administrators have joined forces with other

Socorro Rosado (standing, right), Presbyterian's health educator for seniors, and Jackie Arias, program director at ARC/Ft. Washington Senior Center, discuss health issues with seniors at the Center.



community organizations to solve what was becoming a problem of crisis proportions.

The Hospital's new Ambulatory Care Network Corporation (ACNC) is part of the solution to these problems. ACNC will repopulate the community with physicians in doctors' office practices, and each practice will provide comprehensive, family oriented primary care.

"We're looking forward to the ACNC because it means that seniors will have their own doctors," says Ruth Rossini of the STAR Senior Center. The first ACNC center, which specializes in geriatric care, opened in January in Fort Washington Houses, a residence for seniors.

All ACNC physicians will have clinical appointments at the Hospital and faculty appointments at Columbia

University. While able to control their own practices, they will be freed of some of the business problems of running a practice, so that they can devote their attention to giving quality health care.

"ACNC will be responsive and accessible to the people in this community," says Gerald E. Thomson, M.D., PH executive vice president for Professional Affairs.

"We will bring the full technical and academic abilities of the Medical Center, combined with the organized concerns of the communities, to a system of sensible, coordinated and reliable care."

### **Caring for the Homeless**

Homeless people are a tragedy of our times, and those who suffer from mental illnesses seem especially hopeless.

Now, Presbyterian's Psychiatric Shelter Program, funded by New York City's Department of Mental Health and staffed by Hospital personnel, helps mentally ill residents of the Fort Washington men's shelter find more permanent housing and become more independent.

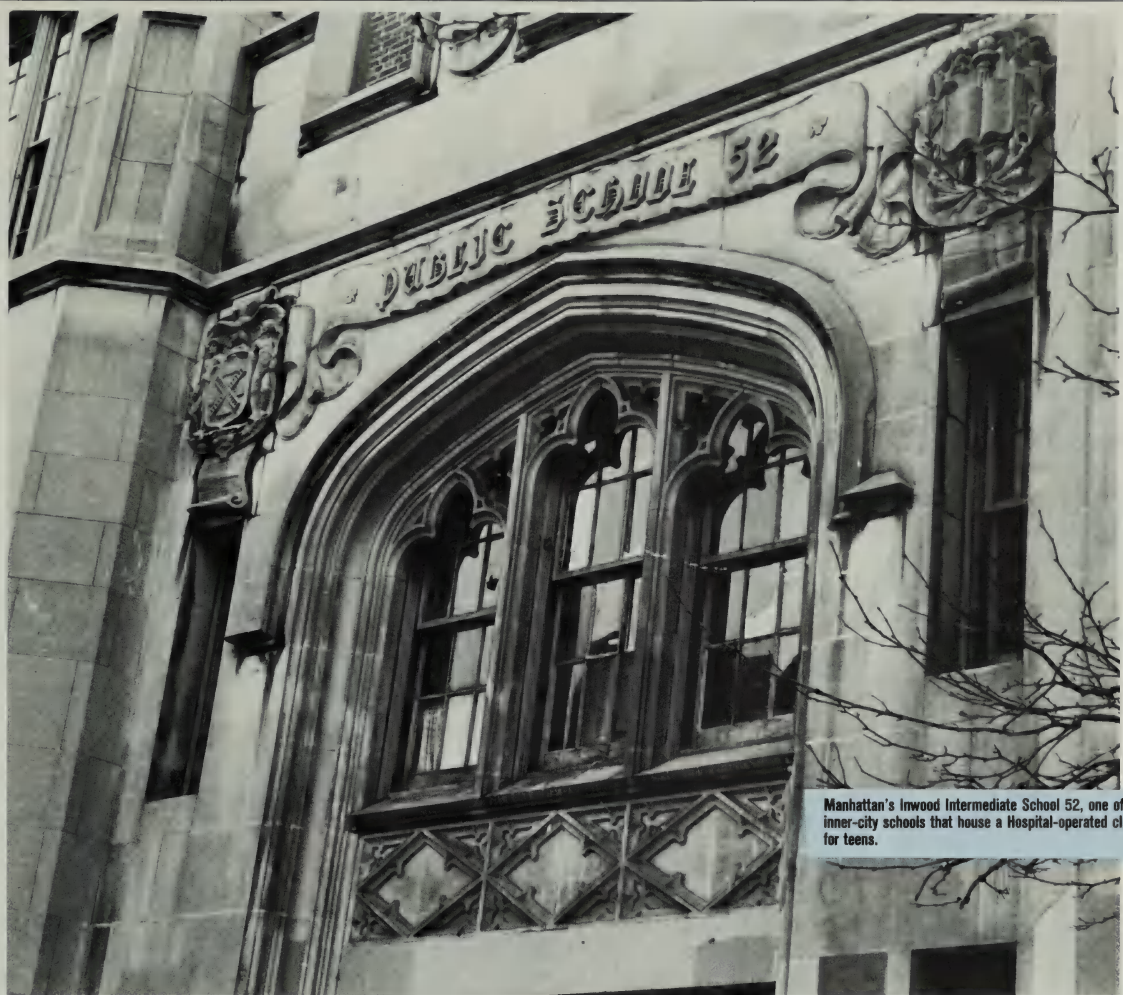
"For these men, homelessness has become a way of life," says Jeff Grunberg, director of the program for mentally ill homeless. "By the time they get to us they're not connecting to anyone, they're not caring for themselves and they can't keep even the simplest schedule."

Through the program, a team consisting of a psychiatrist, psychologist, nurse, social worker, recreational therapist, security officer, and mental health aide work with each homeless man. They plan regularly scheduled

Jeff Grunberg (standing), helps mentally ill homeless men find appropriate housing options through Presbyterian's Psychiatric Shelter Program.







Manhattan's Inwood Intermediate School 52, one of two inner-city schools that house a Hospital-operated clinic for teens.

activities, teach the men about basic health concerns and help them with day-to-day coping skills. They also encourage the men to develop at least one close friendship, and try to keep friends together when they leave the shelter.

"We had one man in here, Philip, who was extremely withdrawn," Mr. Grunberg says. "The only time he spoke was when he'd walk right up to your face and say, 'ping-pong,' or 'lemon meringue.' He eventually began talking and relating to people, and turned out to be very articulate and intelligent. We soon were able to place him in a residence downtown, where he will have support services and still be responsible for himself. Right before he left he came into my office, looked me straight in the eye and said, 'lemon meringue.' We both laughed."

"A lot of other programs won't work with these people," says Ralph Robertson, the social worker with the program. "They complain that they're too bizarre or too dirty. We are sometimes the first ones to accept the person on his own terms."

#### Clinics for Teens

In a new program, the Hospital has located two clinics that specialize in adolescent medicine in local junior high schools. The program, which was developed by the University's Center for Population and Family Health, is co-sponsored by Columbia University and supported by several private foundations.

With the consent of their parents, young teens can receive a variety of health services, from complete evaluations to immunizations and coun-

seling about family, mental and emotional problems. Clinic staff may refer teens to the Young Adult Clinic at Presbyterian, drug and alcohol programs, and other specialty health services if needed.

"We've been swamped with kids," says Andrea Marks, M.D., medical director of the program. "Frankly, it surprised me to see so many students coming to us on their own."

Dr. Marks says each clinic sees an average of 20 students daily. "Parents often come in to talk," she says. "That's very positive."

The major advances in health care, which often put Presbyterian in the headlines, are important worldwide and, of course, to the local community. But, quietly, these local health care networks also greatly contribute to the community's good health. ■

### First Founder's Day Honors Major Contributors

Columbia-Presbyterian Medical Center held its first Founder's Day ceremonies to honor the philanthropists of today whose vision and generosity ensure the strength of the world's first academic medical center. Harkness Medallions were presented to Charles Allen, Jr., Herbert Allen and the Sherman Fairchild Foundation.



COLUMBIA-PRESBYTERIAN MEDICAL CENTER  
**EDWARD S. HARKNESS**  
FOUNDER

The Allens made a joint gift of \$15 million toward the construction of a new full-service community hospital in northern Manhattan, which will be named for their parents, Charles F. and Frances Allen. The Sherman Fairchild Foundation, headed by president Walter F. Burke, contributed \$6.1 million to establish an information/communications center in the new Presbyterian Hospital building now under construction.

The Medallions are named in honor of New York philanthropist Edward S. Harkness, who, perhaps more than any other individual, was responsible for making the Medical Center a reality. ■

### Chronic Lung Disease in Premies May Be Preventable

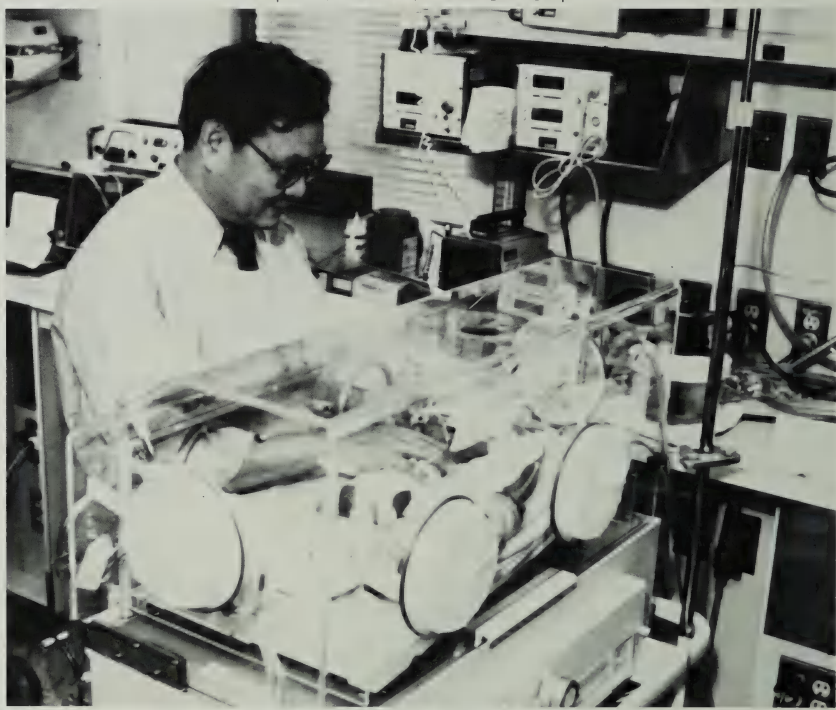
Chronic lung disease in low birthweight infants, thought to be an inevitable consequence of prematurity, may be preventable according to a landmark study conducted at eight major neonatal referral centers, including The Presbyterian Hospital. The study concluded that there are major differences in outcome even among the most advanced neonatal units, and that these are most

likely the result of significantly different approaches to patient management because no other factors could be identified.

PH had much less of a problem with chronic lung disease than any of the other centers.

According to the study, which was published in the journal *Pediatrics*, PH perinatologists may have fared better because they: provide newborns of all birthweights in respiratory distress with oxygen through nasal prongs

soon after birth, which is an uncommon practice; attempt to wean intubated infants from respirators earlier than other physicians; permit carbon dioxide levels in the blood to rise to the 50-60mm range, rather than risk unnecessary trauma due to artificial ventilation; and have a single dedicated perinatologist—Dr. Jien-Tien Wung, associate attending anesthesiologist—who supervises ventilatory care full-time in the neonatal intensive care unit. ■





## Study Identifies Drugs That Prevent Sudden Cardiac Death

A major national study, the Cardiac Arrhythmia Pilot Study (CAPS) conducted at PH/CPMC and ten other centers, identified two drugs—encainide and flecainide—as highly effective in suppressing certain abnormal heart rhythms that occur in patients who have had heart attacks.

According to Dr. J. Thomas Bigger, attending physician and chairman of the CAPS steering committee, the study laid the groundwork for a large-scale clinical trial to determine

whether treatment with anti-arrhythmic drugs will prevent sudden cardiac death. The large-scale trial is slated to begin this year at some 100 hospitals, including PH. About 5,000 patients will be enrolled in this study, which is expected to cost \$60 million. Both CAPS and the large-scale trial (CAST, or Cardiac Arrhythmia Suppression Trial), are sponsored by the National Heart, Lung, and Blood Institute.

Because sudden cardiac death claims some 400,000 victims in the U.S. each year, the success of CAPS is an important step in combating a major killer. ■



## Satellite Conference Opens New Era in Communications

CPMC's Comprehensive Cancer Center participated in a live satellite teleconference presented by the American Society of Clinical Oncology and the Hospital Satellite Network. The teleconference, the first of its kind at CPMC, addressed the latest developments in cancer treatment.

"This is history in the making," said the director of the Cancer Center, Dr. I. Bernard Weinstein, who also is an attending physician on

PH's Medical Service. "In the next decade, all institutions of higher learning will be using satellites to communicate, instruct and inform." The Cancer Center now has installed its own permanent satellite receiver dish on the roof of the Hammer Health Sciences Center, which it is making available to colleagues at the Medical Center. Programs eventually will be available at numerous locations around the Medical Center, in conference rooms, doctor's offices, staff training areas and, possibly, on patients' bedside TV monitors in the new Hospital. ■

## ADMINISTRATION

Victor G. DeMarco was appointed vice president for finance and chief financial officer of The Presbyterian Hospital. Prior to his promotion, Mr. DeMarco was controller and acting CFO. He joined PH in 1978.



H. "Bud" Munson has been appointed vice president of human resources. Mr. Munson received his education in business administration and personnel from Fairleigh Dickinson University. He came to PH in 1979 from Western Union Telegraph Co., where he was personnel services director.

## ANESTHESIOLOGY

Dr. Edward D. Miller, Jr., has been appointed director of the Anesthesiology Service at Presbyterian and E.M. Papper Professor and chairman of the Department of Anesthesiology at P&S. He succeeds Dr. Henrik Bendixen, who became dean and vice president for Health Sciences. Dr. Allen I. Hyman had served as acting director from November 1985 to August 1986.

Dr. Miller comes to Presbyterian from Virginia Medical Center, where he was professor of anesthesiology and surgery and medical director of the surgical intensive care unit. Noted for his research on blood pressure during anesthesia and surgery, Dr. Miller received his medical degree from the Rochester School of Medicine and Dentistry and completed his residency at

Boston's Peter Bent Brigham Hospital.

Dr. Mieczyslaw Finster, attending anesthesiologist at PH and professor of Anesthesiology at P&S, delivered a University Distinguished Lecture at the Queen's University in Belfast, Northern Ireland. The September 1986 lecture was entitled, "The Anesthesiologist's Role in the Management of Obstetrical Emergencies." After his talk, Dr. Finster spent a week lecturing at several British medical centers as a Rank Educational Traveling Fellow of the Royal College of Surgeons.

## DENTISTRY

Dr. Irwin D. Mandel, attending dentist and director of the Center for Clinical Research of the School of Dental & Oral Surgery, delivered the third-annual Seymour J. Kreshover Lecture of the National Institute of Dental Research at NIH. The topic of Dr. Mandel's speech was the function of saliva in maintaining the health of teeth and the mouth. The lecture series was established to recognize outstanding scientific accomplishment in basic and clinical research, and to honor distinguished scientists who have made important contributions in fields directly related to the research of the NIDR.



Dr. Eugene P. LaSota, associate attending dentist, has been elected president of the New York Academy of Dentistry.

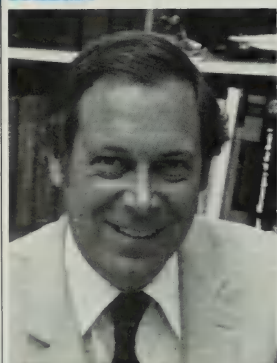


"Clowns on Call" from the Big Apple Circus visited young patients at Babies Hospital in a pilot program that helps children develop a positive attitude toward their illness. The program was featured in *The New York Times* and on NBC Today.

## MEDICINE

Dr. DeWitt S. Goodman, attending physician, was awarded an honorary doctorate of medicine from the University of Oslo, Norway. The award was presented in conjunction with the University's 175th anniversary ceremonies. Dr. Goodman was cited for his major contributions to the fields of cholesterol metabolism, vitamin A and retinoids, and for his leadership roles as a consultant to the National Institutes of Health and the American Heart Association concerning policy in the areas of cholesterol, atherosclerosis and heart disease. Dr. Goodman also is Tilden-Weger-Bieler professor of Preventative Medicine at P&S.

## NEUROLOGICAL SURGERY



Dr. Bennett M. Stein, director of Service, lectured on arteriovenous malformations and pineal tumors to Russian

neurosurgeons in Moscow, Leningrad and Tbilisi. The visit followed the signing of an agreement among the Department of Neurological Surgery at P&S, the Stony Brook Medical Conference of the Harry Winston Research Foundation and the U.S.S.R.'s Burdenko Neurological Institute of the Academy of Medical Sciences to draft a working plan for cooperation in the field of neurosurgery. This will be considered at the eighth session of the U.S.-U.S.S.R. Joint Committee on Health Cooperation, to be held in the spring of 1987 in Washington, D.C. Dr. Stein, who also is Byron Stookey professor and chairman of the Department of Neurological Surgery at P&S, will retire from the editorial board of *Archives of Neurology*, on which he served for a decade.

## NEUROLOGY

The Colleen Giblin Charitable Foundation, which supports pediatric neurological research, together with the Division of Pediatric Neurology, has established a lecture series. The purpose of the series is to bring scientists to the Medical Center who are actively involved in the investigation of aberrant nerve cell growth and the treatment of nervous system tumors. The Foundation and Lecture were established by Mr. and Mrs. Paul Giblin in

memory of their daughter, who died of brain tumor. Dr. Darryl DeVivo, director of the division, is scientific adviser to the Foundation.

## ORTHOPEDIC SURGERY

Dr. Charles S. Neer, II, attending surgeon and chief of the shoulder service, presented a paper, "Recurrent Dislocations of the Shoulder," at the American Orthopaedic Association meeting in Virginia. He also was appointed to the editorial board of the *Journal of Arthroplasty*.

## PATHOLOGY

Dr. Michael L. Shelanski has been appointed director of the Pathology Service at Presbyterian and Francis Delafield Professor and chairman of the Pathology Department at P&S. Dr. Shelanski is internationally recognized for his pioneering studies of the cytoskeleton, and particularly the structure of the cytoskeleton of neurons.

Dr. Shelanski attended Oberlin College and received the M.D. degree from the University of Chicago School of Medicine and the

## First CPMC Consultation/Referral Directory Published

The first comprehensive directory listing CPMC physicians and dentists according to specialty has been published for doctors and dentists only. In response to a mailing announcing the directory, nearly 6,000 health care professionals in the New York metropolitan area have ordered a copy. It is expected that thousands more will order and use this essential tool to find the best available referrals for their patients and to consult with CPMC experts.

In addition to detailed information about the almost 700 physicians and dentists listed, including

Ph.D. in biophysics and physiology from Chicago's Division of Biological Sciences.

He has been on the faculty at Albert Einstein College of Medicine and served as a Guggenheim Fellow and Visiting Scientist in the Department of Molecular Biology at the Institut Pasteur in Paris. He also worked as a staff investigator in the Laboratory of Biochemical Genetics at NIH.

Dr. Shelanski comes to PH from New York University School of Medicine, where he was professor and chairman of Pharmacology. He takes over from acting chairman Dr. John J. Fenoglio, Jr.

## PATIENT REPRESENTATIVES

Norma Shaw Hogan, MHA, director of the Patient Services Departments, recently presented a lecture entitled, "Handling Patient Complaints," at the Connecticut Hospital Association's continuing education program on "Maintaining Partnerships with Patients and Staff: A Challenge for Patient Representatives."

Hospital and P&S titles, education and internship/residency and specialties, the directory also provides information about the Medical Center's many divisions and components.

The directory is a major element of the Columbia-Presbyterian Consultation/Referral Service. The second element is a computerized database, maintained by experienced people who provide prompt information about CPMC staff, programs and facilities. The database contains all the information provided by the directory, plus additional information such as a practitioner's foreign language capabilities, office locations and additional areas of expertise or specialty procedures.



## PEDIATRICS

In December, the United Hospital Fund awarded a \$40,000 special project grant to PH to create a resident-staffed pediatric group practice with a 24-hour bilingual telephone consultation service which provides continuity of care to an inner-city population. *David L. Ginsberg* (below center),

vide members of the staff of both Houses of Congress and of various health and human services agencies with updates on issues in psychiatry.

*Dr. Michael Liebowitz*, associate attending at PH and associate professor of psychiatry at P&S, addressed the APA on the subject of social phobias and other



executive vice president for planning and program development, accepted the award from Bruce C. Vladeck, president of the United Hospital Fund, and Mrs. Herbert Greenberg, chairman of the Fund's Distributing Committee. *Dr. Matilde Irigoyen* manages this program, which has additional support from the New York Community Trust and Morgan Guaranty Trust Co. Charitable Trust.

## PSYCHIATRY

*Dr. Herbert Pardes*, director of the PH psychiatry service and chairman of psychiatry at P&S, presented an overview of the great strides research has made in psychiatry at an American Psychiatric Association symposium in Washington late last year. The APA holds the symposium each year as part of Mental Illness Week to pro-

vide members of the staff of both Houses of Congress and of various health and human services agencies with updates on issues in psychiatry.

*Dr. Donald S. Kornfeld*, attending psychiatrist, contributed to the National Institutes of Health Consensus Development Conference Statement on an Integrated Approach to the Management of Pain. *Dr. Kornfeld* also is professor of clinical psychiatry and associate dean of P&S.

*Dr. Steven Roth*, assistant psychiatrist, received the Van Ameringen Young Investigator's Award for Research in Schizophrenia. The award consists of a four-year grant for \$250,000, which *Dr. Roth* will use to work at the Special Treatment Unit (STU), a collaborative research facility located at Creedmoor Psychiatric Center. STU is staffed by researchers from the New York State Psychiatric Institute, Creedmoor and the Department of Psychia-

try at P&S. He will work on the development of alternative strategies to current schizophrenia medications, which have serious limitations.

## RADIATION ONCOLOGY

*Dr. James Cox*, director of service, has been appointed chairperson of the board of directors of the American Society for Therapeutic Radiology and Oncology.

*Dr. Ritsuko Komaki*, assistant attending, presented a paper at the annual meeting of the Radiological Society of North America, held late last year, on the benefits and drawbacks of irradiation treatment for advanced cancer of the genitourinary tract.

## SURGERY



*Dr. Norman E. Hugo*, attending surgeon and chief of the Division of Plastic and Reconstructive Surgery, was named president of the American Society of Plastic and Reconstructive Surgeons (ASPRS). ASPRS, with 2,700 members, is the nation's largest organization of board-certified plastic surgeons. *Dr. Hugo* also is professor of surgery at P&S.

*Dr. Ivo P. Janecka*, former associate attending surgeon, has been named chief of the Division of Head and Neck Plastic Surgery and co-director for the Center for Craniofacial and Skull Base Surgery at the University of Pittsburgh School of Medicine-Eye and Ear Hospital.

## Hispanic Health Conference: Call for Speakers

The Columbia-Presbyterian Medical Center and the Universidad Autonoma de Santo Domingo are sponsoring a Conference on Hispanic Health Care Approaches in New York: A Focus on Dominicans, in early October 1987. Anyone interested in speaking at the conference should contact *Dr. Katherine F. Darabi*, 60 Haven Avenue, B-3, New York, NY 10032.



## IN MEMORIAM

*Anne Walters*, secretary to *Dr. Benjamin P. Watson* for 25 years, died last year. Following *Dr. Watson's* retirement as head of the Obstetrics & Gynecology Service at The Presbyterian Hospital, she remained to serve *Drs. Stanley M. Byssse* and *C. Paul O'Connell*. Until July, she was secretary to *Dr. David M. Ju*, associate attending surgeon. "Hers was an outstanding career of service to others," writes her long-time friend, *Frederick S. Merriam*.

*Dr. Winifred Bronson Leland*, former allergist at PH, died December 6 at her home in Riverdale. She was 81 years old.

Known professionally as *Dr. Bronson*, she attended P&S, where she met her future husband, *James Leland, M.D.* She graduated in 1933 and completed her internship and residency in internal medicine at the Columbia Division of Bellevue Hospital. Memorial services for *Dr. Bronson* were held at her family home.





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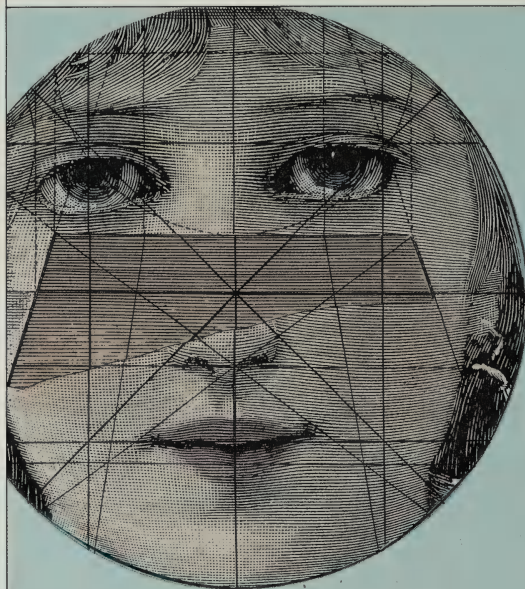
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## AN ELEGANT ART

Medical news often emphasizes the development of artificial hearts and other tissues and organs. Yet perhaps the most demanding and innovative surgery being done today takes advantage of the superabundance of "raw materials" with which nature has endowed us and makes use of our own "spare parts."

The first recorded autogenous transplants date back to India in the 7th century B.C., when physicians rotated a "pedicle flap" from the forehead 180 degrees to reconstruct the nose. (Nose deformities were common in ancient times, because of war injuries, leprosy and syphilis. Also, an amputated nose was a frequent punishment for adultery.) The head and neck have abundant blood supplies, which contributed to the success of these transplants.

Another technique, in which noses and lips were reconstructed using the skin and blood supply of the upper arm, was perfected in Renaissance Italy and still is used, although rarely, to this day. It involved cutting a wide flap from the arm and attaching it to the area to be reconstructed, using a canvas or leather garment to keep the arm, head and flap from moving.



From start to final healing, the arm had to remain attached to the face for anywhere from three to five months, and the operation was done entirely without benefit of anesthesia. Physicians' assistants were very strong in those days! Their most important task was to hold the patient down.

Spare parts surgery has become far more sophisticated since then. Thanks to recent advances, in particular the advent of the operating microscope and the development of the myocutaneous flap, increasingly surgeons are taking tissue—bone and muscle, often with blood supply intact, cartilage, skin and even parts of the intestine—from one part of the body to repair structures elsewhere that have been damaged or destroyed by disease or accident.

Many of these surgical procedures, such as the coronary bypass and spinal fusions, have become so routine that we take them for granted, yet they depend on spare parts surgery. Spare parts reconstructions today take place in hours, rather than months, and involve virtually every body system. What remains constant is the basic, ingenious idea of taking one body part to repair another.

# SPARE

*It's no accident that our bodies have two ears, two eyes, two kidneys and two lungs. In a way, they're insurance that we'll survive a variety of diseases and injuries, since we can make do with only one of each. And where evolution hasn't given us spare organs, it has endowed us with ways to compensate for loss. If, for example, one part of the brain is injured, it's likely that another portion can 'rewire' itself and take over the lost function.*







# PARTS

*Unfortunately, the body is not prepared for every contingency. Birth defects, disease and injury too often take their toll. Perhaps in a hundred thousand more years, we will evolve into a superhuman race with even more spare parts, greater compensatory mechanisms, or even the power to regenerate what is lost.*

*In the meantime, surgeons at The Presbyterian Hospital/Columbia-Presbyterian Medical Center can rebuild a remarkable amount of the body.*



when its own healing powers fail. Skin, muscle, fat, bone, intestine, blood vessels, tendons and nerves can be remodeled to reconstruct hands, arms, legs, ankles, jaws, noses, inner ears, breasts, bladders, ureters and urethras. To be sure, the new parts are not always like the real thing, but they can turn lives around, and even save them.

## Bone Transplants

Watching an active youngster play in front of her New Jersey home, you wouldn't think that only a few years ago she was a possible candidate for leg amputation. Jane (not her real name) was born with neurofibromatosis, a rare congenital disorder that sometimes causes sections of bone to disintegrate. By the time Jane was three, the shin bone in her right leg was so soft that it bowed as much as 45 degrees, even with a cast.

Jane's leg was saved by a fibular transplant, an unusual and relatively new procedure. According to Dr. Harold Dick, Director of Orthopedic Surgery at PH and Frank E. Stinchfield Professor and Chairman of Orthopedic Surgery at P&S, the procedure involves the removal of a piece of healthy bone from the fibula of the normal leg. (The fibula is the thinner of the two long bones in the lower leg.) "The fibula is not an essential bone," he says. "Removing it does not weaken the leg, because the tibia bears almost all the weight."

The fibula segment—with its blood supply—then is transplanted into the impaired leg, replacing the diseased bone tissue. The transfer of blood vessels is the key to this lengthy operation. Using intricate microsurgical techniques, the doctors reconnect the fibula's blood vessels to that of the damaged leg. This restores blood flow to the marrow of the transplanted fibula and greatly reduces healing time. In a matter of months, as weight gradually is applied to the leg, the transplanted fibula thickens until it is strong enough to bear the patient's full weight without braces.

Fibular transplants, according to Dr. Dick, also are used to treat legs impaired by infection, tumor or trauma.

Ordinarily, orthopedic surgeons first turn to cadaver bone, which is stored in special freezers in a bone bank, to repair many bone defects. But some defects resist healing or create gaps too large for treatment with donor bone. "When donor bone is used in segments longer than two inches," explains Dr. Dick, "it often dissolves, shrinks and breaks. But the healing with live bone is excellent,

because it has its own blood vessels."

Technically, doctors could use live donor bone, but that raises the threat of organ rejection—a risk not worth taking when the patient's life is not at stake. "The advantage of a fibular transplant is that the patient can donate his own bone. This allows the surgeon to perform the procedure without having to worry about damaging side effects or to wait for immunological breakthroughs," Dr. Dick says.

## Limb-Lengthening

In most cases, bone injury is less serious for children than for adults. Children's bones fracture less frequently and heal more rapidly. But they also are more susceptible to injury to the growth plates, the areas responsible for most longitudinal growth. Located at the upper ends of most bones, growth plates can be permanently switched off if fractured, crushed or infected.

For children with injured growth plates, as well as others with congenital shortness of one limb, an innovative procedure can lengthen the affected extremity. In a rare operation, the affected bone is cut and gradually pulled apart by means of an external device that is pinned to the two bone segments. The limb is lengthened about two millimeters a day, to a maximum of about two inches.

"Once we've achieved the desired length, we introduce bone fragments, usually from the pelvis, and fuse the two parts," according to Dr. Dick. "Lengthened bones have normal strength after a few months."

Most limb-lengthening operations involve the legs; however, the technique can apply to the arms. "Arm lengthening generally is not performed unless the discrepancy in length is very significant. Whereas a discrepancy in leg length affects the spine and the rest of the skeleton, an arm length discrepancy has no similar repercussions," says Dr. Dick.

## Growing Skin Through Tissue Expansion

For years, plastic surgeons have been taking skin from one part of the body to repair the damaged or missing skin of another part. But sometimes, there's not enough skin for grafting, or the graft provides a poor, unsightly match. Today, these factors need not be limitations, thanks to doctors who recognized that pregnant women could teach them a thing or two about skin growth.

During pregnancy, the skin stretches and grows to accommodate the ballooning abdomen. The same principle can be

used to get patients to grow extra skin for themselves. This is done by implanting tissue expanders under the skin—clear plastic pouches with self-sealing valves—and gradually filling them with saline (salt) solution. As the pouches expand, they stimulate skin growth.

After several months of artificially induced tissue expansion, a plastic surgeon can take the extra skin and use it to make repairs. Anywhere there's skin, a tissue expander can be inserted, according to Dr. Norman Hugo, Chief of the Division of Plastic and Reconstructive Surgery at PH and Professor of Surgery at P&S, who uses this technique.

One advantage of tissue expansion over conventional techniques is that skin can be made to grow in areas adjacent to the graft site. Thus, the graft will closely match the surrounding tissue.

Sheila Finn of Poughkeepsie, N.Y., was one of the beneficiaries of this technique. Ms. Finn, a college student, had a skin graft when she was nine to cover a gap where a potentially malignant birthmark was removed. Skin from her buttocks was used for the graft, but it didn't match well. She's been uncomfortable with it ever since.

Growing up, "I was more quiet than I would have been if I didn't have a scar," she says. Although she was captain of her high school tennis team, she wore Bermuda shorts rather than more revealing styles. "I limited myself, because I didn't feel comfortable wearing shorts."

Ms. Finn entered PH last December to begin the process of tissue expansion that would allow Dr. Hugo to replace the graft. To yield enough skin, Dr. Hugo implanted two tissue expanders, roughly the size and shape of wineskins, at the edges of the graft on her left thigh. Ms. Finn recovered in the hospital for one week and at home for another. Then she returned to college in upstate New York.

Twice a week, she visited a local plastic surgeon for saline injections to make the pouches expand. The only discomfort was her self-consciousness over the increasing size of the tissue expanders, which by the day of the second operation bulged from the front, back and side of her thigh. "I wore big skirts to class," she says.

The devices produced roughly 50 square inches of additional skin—enough to replace 70 percent of the original graft. Dr. Hugo and his team removed the pouches, pulled the expanded skin over the old graft, marked the overlap and left it to relax awhile. Since they marked the overlap before the new skin relaxed, the

surgeons could take enough time to carefully cut away the skin being replaced from the underlying tissue. Then they stretched the replacement skin and sutured it in place.

Ms. Finn plans to return in the summer or early fall to replace the remaining section of the old graft with skin produced by tissue expanders.

Plastic surgeons also can use expanded tissue to repair tumor damage and abnormal bodily depressions, and even to treat baldness. The technique one day may provide extra hair-growing skin to treat

male pattern baldness. Right now it is used to treat baldness caused by disease or trauma, as in the case of burns.

Tissue expansion even can help rescue damaged limbs. "We saved a child's leg," Dr. Hugo recalls. "He needed a bone graft, and he didn't have enough tissue to cover it. If you don't have enough soft tissue for coverage, the bone graft will fail."

### Finally, A Potential Use for Extra Fat

One of the more frustrating aspects of dieting is that you never seem to lose

weight where you want to. You end up with skinny arms when you want skinny legs.

If only you could move that fat around to reshape your body. Actually, doctors at PH soon may be doing this, although not as a dietary assist, but as a way to repair bodily defects.

During liposuction, a new non-surgical fat-removal procedure, a blunt tube is used to draw fatty tissue from between skin and muscle. This technique is used here to remove unwanted fat in selected patients. Recently, doctors in France found that they also could reinject the material elsewhere—e.g., where needed to repair defects—and that it would "take."

Because fat has few blood vessels of its own, skin, with its more abundant blood supply, generally is transferred with fat during plastic surgery to ensure that the fat receives proper nourishment. But it now appears that suctioned fat can attract a blood supply from its new surroundings. This is important because skin-fat grafts often fail; under the best of circumstances, they shrink by one-third of their original size and often become scarred and turn to hard lumps. An artificial alternative—silicone—can push its way out through the sutured incision.

The injected fat seems to stay supple and well-contoured. It also is more easily shaped to its new contours than is a graft, and the surrounding tissue helps hold it in place.

It is expected that the new technique first will be applied to repair small areas, about the size of a half dollar, where trauma, birth defects, or surgery have created depressions by destroying the existing fat. "Fat is what makes your body smooth," says Dr. Hugo, "and when you lose fat in a circumscribed area, you have a visible defect."

Plastic surgeons at PH expect to use liposuction and injection first on facial defects, because of the face's abundant blood vessels. Donated fat will come from the patient's hips, buttocks, and so on—"where there's plenty," says Dr. Hugo.


"This is absolutely, totally unexpected," he exclaims. "This is something we would have predicted wouldn't work, but it seems to work." No one yet knows just why, or what the long term prognosis and risks are—those answers might be years away. It must be shown that the early successes aren't just an aberration, and that the transplanted tissue can live out the life of the patient.

But if the first tries succeed, the doctors may begin using liposuction and injection to repair larger areas and other



Dr. Norman Hugo with liposuction device. Dr. Hugo uses liposuction to remove unsightly fat. A surprising development from France is the use of liposuctioned fat to repair defects.





Many women today choose breast reconstruction, which can be done simultaneously with surgery.

body parts besides the face. Dr. Hugo predicts it will be done on an outpatient basis someday.

### Moving Living Tissue Without Disconnecting Its Lifeline

Perhaps the most significant reconstruction tool of the plastic surgeon is the myocutaneous flap—a slice of muscle and skin that can be moved together with its vasculature to repair tissue damage. When accident or surgery leaves a gap of tissue in the body, a flap can be cut free from one part of the body and moved to another to cover defects. This is done with the blood supply and sometimes the nerves, by sliding the flap under the skin to its new location.

"It's really opened everything up for us," says Dr. Hugo. Flaps may be taken from the entire lower or upper abdomen, the front or back of the thigh, the tissue covering the shoulder bone, or the scalp. They're commonly used to reconstruct noses or breasts, to cover chest wall or scalp defects, and to heal pressure sores.

The patient, of course, is not left with a gaping hole from where the flap is taken. Flaps are moved from areas with tissue to spare, which is why the abdomen and thigh are good sources. The remaining tissue is sutured together, covering up the

loss of the skin and muscle.

The loss of a major piece of muscle would seem to strip the donor site of its own mobility. "Surprisingly, the donor part of the body normally doesn't lose its ability to move," Dr. Hugo reports. Nearby muscles grow larger to make up for the loss.

Although flaps contain muscle, the purpose here is to repair defects in the body's contours or features, not to restore muscle function. "The muscle in this application is only a conduit for blood vessels; it's not meant to provide movement," Dr. Hugo explains. (Muscles also can be transplanted to regain limb function. See below.)

For Susan Purdy, a young mother from Queens, a myocutaneous flap did more than fill out a contour—it covered vital organs left exposed after a sternum infection. Part of the soft tissue covering her breast bone had deteriorated and part had been cut away to get rid of the infection. She was left with a four-inch-wide hole that stretched from her throat to the top of her belly. In March of last year, Dr. Hugo's plastic surgery team took flaps from Ms. Purdy's pectoralis, or chest muscle, and from the rectus abdominus muscle at the top of her abdomen. In the process, the surgeons not only repaired

the gap, but did away with the unsightly scar of Purdy's previous operation.

"My scar is just a simple line," she says. "It's fantastic, when you consider that I had a hole in my chest. At my beach club, I was able to wear a bathing suit and no one noticed."

### Rebuilding the Breast

Each year, over 100,000 women in the U.S. develop breast cancer, about half of whom have mastectomies. Not too long ago, that meant certain and substantial disfigurement, physical and psychological, as the breast and underlying muscle and lymph nodes were removed.

In the early 1970s, the advent of the modified radical mastectomy, which retains the large chest muscle, set the stage for plastic surgeons to reconstruct the breast, often simultaneously with the mastectomy, but sometimes years later. Various types of reconstruction are available, some including synthetic implants. But more natural results can be achieved using myocutaneous flaps. In one method, a flap from the latissimus dorsi muscle, located below the shoulder blade, is slid around, with its blood supply, under the skin to the chest to build a breast mound, under which an implant is placed.

An even better result comes from the most complicated method of breast reconstruction, the RAM flap. In this technique, plastic surgeons transfer a flap of the rectus abdominus musculocutaneous (RAM) tissue from the abdomen to the chest wall. According to Dr. Hugo, one of the leading breast reconstruction surgeons, "The tissue in the abdominal area makes an ideal package for this kind of surgery. The texture of the skin and tissue from this area is the most similar to that of the breast." An artificial implant is not needed with the RAM flap, and the patient gets a bonus "tummy tuck" in the process.

After the flap is rotated into place, the artistry comes into play. Dr. Hugo sculpts the breast, trimming off excess skin and fat so that it matches the other breast as closely as possible. At a later date, a nipple and its surrounding pinkish-brown ring can be fashioned from a number of body parts, such as the upper inner thigh.

"Hospitalization after surgery lasts only five days to a week. Within a month, the woman can return to work," says Dr. Hugo. "If chemotherapy is necessary because of concern about remaining cancer cells, it can be started a few weeks after surgery."

"Regardless of whether a woman

receives an implant or goes for reconstruction," says Dr. Sven Kister, Attending Surgeon at PH and Associate Clinical Professor at P&S, "my feeling is that she should have two breasts—that should be the end result. Being without a breast and under continual stress can be very harmful."

### Changing Early Attitudes About Reconstruction

This wasn't always the general attitude toward reconstruction. When Dr. John Conley, Consultant in Otolaryngology at PH and Professor Emeritus of Clinical Otolaryngology at P&S, began practicing head and neck surgery more than four decades ago, reconstruction was considered an unnecessary frill. "The prevailing philosophy about reconstructive surgery, especially with cancer patients was, wait five years," he recalls. "The idea was that reconstructive work was not worth doing if the patient would live only a year or two beyond the surgery."

But Dr. Conley believed otherwise: That reconstructive work was a critical factor in the patient's full emotional and physical recovery. During his long and distinguished career, he has had a major role in encouraging the profession to

accept immediate and extensive reconstruction.

"From the very beginning of my career," he says, "I felt that if a surgeon has to operate on the head and neck, he or she has a professional obligation to get the patient back into the best possible shape. I've always done as much reconstruction work immediately as I possibly can."

Dr. Conley's unusually broad training in otolaryngology, plastic surgery and cancer surgery gives him a unique perspective on reconstruction, which he has used to create new surgical techniques. He was one of the first to use myocutaneous flaps from the scalp, neck, chest and back to repair tissue damage in adjacent areas.

"Reconstructive flaps were one of the most significant developments in my lifetime," he says. "The work developed in an interdisciplinary atmosphere, with contributions from many different surgeons, including otolaryngologists, general and plastic surgeons, and neurosurgeons."

Dr. Conley also works with autogenous (self-produced) nerve grafts. For example, for a patient who has suffered facial paralysis, he might transfer a nerve from the neck or leg to the face. "The face

never will be 100 percent normal," he explains, "but there almost certainly is improvement."

### For Cosmetic and Functional Repair

Importantly, flaps often give patients more than cosmetic improvement. For example, Dr. Conley has resectioned tongues and jawbones damaged from cancer surgery to improve breathing, swallowing and speaking. In 1980, he was among the first to use a chest muscle (pectoralis) flap to re-nerve a tongue. In that case, he operated on a 12-year-old patient who had lost most of his tongue when a benign tumor was removed. Despite poorly matched nerve segments, the flap enabled the boy to move his tongue and swallow and to speak well about ten months after the operation. Before this procedure was developed, a muscleless flap from the upper chest was used, which meant that the reconstructed tongue had no intrinsic movement.

"This procedure opens up new vistas for children with advanced tumors, cases where we never knew what to do for them in the past," says Dr. Conley.

In performing reconstructions, and particularly where more than one option



Dr. John Conley removing a melanoma of the upper lip and reconstructing the lip using a myocutaneous flap from the patient's cheek.



## SAVING LIMBS FROM AMPUTATION

may be available to create a flap, Dr. Conley must decide what will work and look best. In excising an upper lip melanoma, Dr. Conley removed the patient's upper lip and then had to decide whether to take a flap from the lower lip or one from the cheek just above and to the right of the upper lip. As he studied the excision and measured the area to be reconstructed, he realized that taking a flap from the lower lip would leave the patient with a small mouth. After remeasuring and drawing the reconstruction on paper, he recreated the lip using the tissue and skin from the cheek. The entire operation, from excision to reconstruction, took about two hours. After healing, the patient will be left with only a small scar above her upper lip.

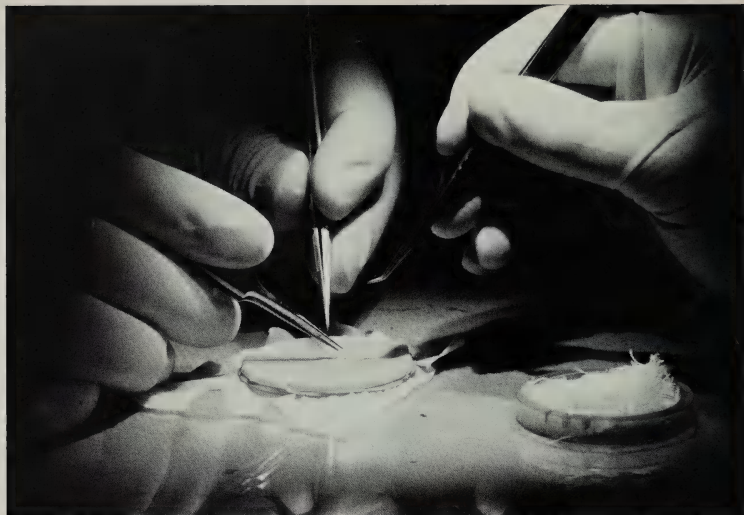
Despite these astonishing advances, Dr. Conley says that myocutaneous flap procedures are still evolving. "The body is a vast, magnificent set of autogenous recycling material. Every year, surgeons are discovering new parts to use for rehabilitation and reconstruction."

### The Long Road to Recovery

One of the most dramatic uses of spare-parts surgery is to regain muscle function in arms and legs. Because movement is the objective, not just coverage (as with conventional flaps), this procedure is more complicated and lengthy.

Although nerves are reattached in these operations, the muscles don't start to function right away. "Once a nerve is severed, it undergoes a process called Wallerian degeneration," explains Dr. Rosenwasser, Assistant Attending Orthopedic Surgeon at PH and Assistant Professor at P&S, "which means the nerve essentially dissolves back to the nearest juncture—sort of a transformer or substation in electrical terms." But the nerve eventually does grow back along its former sheath, which remains intact. Nerve regrowth occurs ever so slowly, about one millimeter per day, or one inch per month.

"We do this operation only when there is a devastating loss. So we do get dramatic recovery, but it's not going to be perfect. For instance, there are about a dozen forearm muscles. We are not going to recover the complex motions of the fingers, as in playing the piano, by transplanting one or two muscles. But it gives you an assistive hand, a hand that instead of lying motionless at your side, can be used to brush your hair or your teeth. We can make your hand useful, but not normal."



Restoring limb function is an extraordinarily complex procedure. The surgeon may have to transfer muscle to restore bone, skin, tendon, other soft tissue, blood vessels and—most importantly—nerves for neuromuscular control. But it's well worth the effort.

"In the past," explains Dr. Melvin Rosenwasser, "when you had massive injuries to a limb, amputation was the only alternative. There was no way you could reconstruct many losses from injuries, infection, tumors or congenital defects."

Either you have a functionless hand, and have to amputate, or you bring a muscle from somewhere else, perhaps the thigh, says Dr. Rosenwasser. "You don't want a limb that just hangs there; it can be more of a hindrance. It's less disfiguring to have an amputation and a prosthesis than to have a nonfunctional part. With these techniques, we can give the patient a limb that's useful."

Such "free" muscle transplants owe their success to the evolution of microsurgical techniques, which allow surgeons to reattach tiny blood vessels and nerves at the new site. The surgeons work under microscopes with needles and sutures, which are barely visible to the naked eye.

These are not everyday procedures, even at a medical center like Columbia-Presbyterian. Only when more conventional flaps or bone grafts fail do Dr. Rosenwasser and his colleagues step in. "Most of the patients that I see have had multiple operations and are candidates

for amputation. In other words, everything has been tried; this is their last chance."

The operations can last up to 15 hours. "You try to prepare for surgery as best you can with various preoperative tests, but the post-trauma anatomy of each case is always a little bit different," says Dr. Rosenwasser. "And there's always the possibility that what you anticipated as being usable is not. Then you have to improvise. There's no predictable endpoint to the operation. The procedure continues until you get a satisfactory restoration of circulation, because the alternative is tissue death and loss of the limb."

Dr. Rosenwasser emphasizes that this is a team operation: "There are no virtuoso performances. A muscle transplant is similar to other organ transplants, with the exception that loss of the transplant is usually not life-threatening."

"Once you detach the tissue from the body, there's a limit to how long it can be without oxygen: For muscles about two to three hours, for skin a little longer, and bone even longer. There's tension and pressure to restore the circulation quickly."

Two surgical teams generally are involved, one to harvest the tissue, another to replant it. As the hours pass, the surgeons spell each other; only two can work under the microscope at the same time. The senior surgeon oversees the operation every step of the way.

## Middle Ear Repair

Like an old-time cabinet maker, Dr. Maxwell Abramson, Director and Chairman of Otolaryngology at PH and P&S, respectively, talks about rediscovering quality workmanship and organic materials. His material consists of tiny pieces of human bone, taken most often from behind the ear, which he sculpts to replace damaged ossicles, the three bones of the middle ear. The idea has been around for 20 years, but it had been overtaken by the use of plastic prostheses.

These so-called autografts "may be more difficult to fashion, but they are biologically superior," says Dr. Abramson. "When you're talking about something that will last 20 years, it doesn't matter if it takes an extra half hour" in the operating room.

The ossicles—named the hammer, anvil and stirrup after their respective shapes—help translate soundwaves into nerve impulses that the brain can understand. As soundwaves beat against the eardrum, their vibration is concentrated through the ossicles and conveyed to the fluid of the inner ear. The fluid's motion sets fine hairs to swaying, stimulating the auditory nerve.

Fracture or infection can damage the ossicles. Surgeons have been using plastic replacements, but Dr. Abramson says these are not as long-lived and sometimes tend to poke through the eardrum. Doctors have tried to prevent that by placing a thin plate of cartilage between the narrow end of the bone and the membrane, but the cartilage often slips off or dissolves.

Not all otolaryngologists agree about the drawbacks of plastic prostheses, Dr. Abramson concedes. "Some people say they get perfect results, but it's usually a short follow-up—six months to two years." Not long after that, in his experience, the plastic replacements may poke through.

It's also possible to use homografts—bones from cadavers. But these carefully sculpted replacements can become misshapen as living tissue grows into the dead bone. The patient's own bone is best, he emphasizes.

To make an autograft, Dr. Abramson takes a piece of skull from behind the ear and reshapes the bone with a drill to suit the patient's needs. If conditions warrant, he can reshape an existing ossicle, then put it in a new position to bridge a gap left by a missing or removed ossicle. Although each original ossicle has its own distinctive form, "you can replace it with something that's not the same shape. The important thing is that it be

the same distance," he notes.

In the case of Robert Richards, a 41-year-old warehouse supervisor from Washington, N.J., Dr. Abramson chose to use one of the two bones that remained in the patient's ear. Mr. Richards had suffered repeated infections that were so severe one bone had disappeared completely. He remembers having such infections since he was four or five years old.

As an adult, he's had a number of operations on both ears. His most recent was this past November, when Dr. Abramson inserted a crutch-shaped piece of bone from the skull to bridge the gap left by the missing bone. The tip of the crutch fits into the bony window of the inner ear.

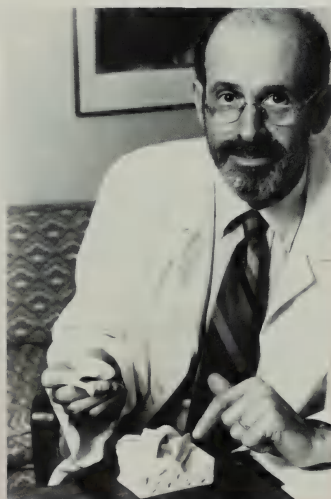
Mr. Richards' previous reconstruction had lasted 10 years; as it failed, his hearing began to fade. "If I was having a conversation with one person and there happened to be a conversation between any number of other persons in the same room, I couldn't distinguish anything," he says. "In a larger room, the voices just disappeared. I couldn't hear the dial tone on the telephone."

Before November, Mr. Richards had begun to rely on lip-reading without realizing it. Eventually, though, the

problem became intolerable. "It took me two years to get up the nerve to have the operation," he says. To his pleasant surprise, there was less discomfort than he had expected.

Mr. Richards was in the hospital for two days and back at work in one week. The two-hour operation was performed under local anesthesia so the patient could communicate with the surgeons, which made possible evaluation of his hearing during the procedure. "On the operating table, I noticed the difference right away," he recounts. "I asked if they were all talking loudly, and Dr. Abramson said no, they were all talking very normally. It didn't correct all my hearing, but I can distinguish the voice ranges."

Dr. Abramson concurs that the bone replacement isn't likely to restore full hearing. Rather, it produces some improvement in about 75 percent of the cases; sometimes it has to be redone. This is natural in an operation of such delicacy, with tolerances of less than one millimeter. "It's very difficult to reconstruct something with such small tolerances that will be exposed to changes in the shape of the middle ear as the tympanic membrane moves in response to pressure changes," he explains.



**Dr. Maxwell Abramson with a model of inner ear bones, or ossicles. Dr. Abramson reshapes bone from behind the ear to replace damaged ossicles.**





It's clear that for Robert Richards, the partial improvement is well worth the effort. He's stopped reading lips.

### Facial Reconstruction

Enabling a young boy to fulfill a life's dream—to eat a “Big Mac”—was one satisfying result of a bone transplant performed by Dr. Steven Roser. Dr. Roser is Director of the Division of Oral and Maxillofacial Surgery of the Dentistry Service at PH and Associate Professor of Clinical Dentistry at the Columbia Univer-

sity School of Dental and Oral Surgery.

He and his colleagues from Dentistry, Orthopedic Surgery and Plastic Surgery use transplanted bone from the hip, clavicle and other areas to repair congenital and accidental facial defects.

The boy had broken his jaw joint after a fall when he was two years old. His parents had waited to see if the wound would heal properly before seeking help, and by the time Dr. Roser saw him he had suffered significant deformity: His teeth were out of line and his jaws were

developing asymmetrically, so that opening his mouth to speak clearly—or to eat a hamburger with “the works”—was virtually impossible.

To repair the damage, Dr. Roser removed a piece of the boy's seventh rib and transplanted it to the injured area. “The rib has cartilage where it connects with the sternum,” Dr. Roser explains. “This cartilage serves as a growth center.

“There is a famous theory devised by Dr. Melvin Moss, who is Professor of Anatomy at P&S, that form follows function,” Dr. Roser says. “What we do is restore function, and, true to the theory, form—meaning a more normal appearance—follows.

“The boy now is about 12, and the growth on the injured side has nearly caught up with the healthy side,” Dr. Roser says. “It was worth everything to see him so happy after he finished his first big burger.”

“Spare parts” also are used in dentistry to replace teeth. “If a youngster has had poor dental care and his first molar has decayed, we may be able to replace it with a healthy third molar or wisdom tooth,” Dr. Roser says. Such a transplant can eliminate the need for a bridge.

Dr. Roser also uses spare parts to reconstruct damaged ridges in the gums, which hold teeth in place. “If there is enough bone in the jaw,” Dr. Roser says, “we can rebuild these ridges, using skin and bone from the buttocks or thigh. It's important because there are about 15 million people in this country with false teeth, and probably half of them can't wear dentures because of extensive damage to gums and bone.”

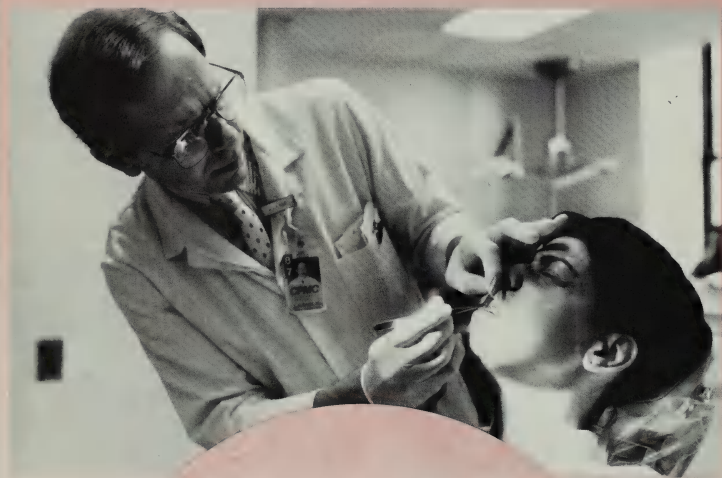
Sometimes in removing wisdom teeth, the nerve that supplies feeling to the lower lip may be injured in a way that numbness and pain result. Dr. Roser may replace the damaged mandibular nerve with one from the ankle or from behind the ear. “These microneural surgical repairs are difficult and may not work, so we only do them if the injured nerve causes pain rather than numbness,” Dr. Roser says.

### Hand Reconstruction

About seven out of every 1,000 babies are born with some birth defect. Of those seven, one usually is a hand deformity. According to Dr. Robert Carroll, Chief of the Division of Hand Surgery on the Orthopedic Surgery Service, many of those children are candidates for reconstructive hand procedures—many of which were developed or perfected here.

One of Dr. Carroll's patients is Denise

Dr. Steven Roser examines a patient whose jaw has been reconstructed using skin and bone from the thigh.



SUD:HR

Malangone, who was born essentially with no right hand. At birth, her right arm ended with a slight swelling at the wrist, where her hand normally would have been.

"I first saw Denise when she was two years old, and she had her first operation just before she started kindergarten," Dr. Carroll says. "Since she had developed a few carpal bones, which are the bones at the base of the palm," he explains, "we divided these using a distraction device." This device had pins that could be turned with a screw to separate the cut bone.

"Every day we had to tighten the screws one-half turn," remembers Mrs. Malangone. "We just kept turning the screws until it started to elongate her hand, stretching the skin until it grew about three inches.

"The next operation took place when Denise was five. They took out the metal apparatus and took strips of bone from her pelvis and implanted them into her hand, which was put into a cast for two months."

This procedure lengthened the "hand," Dr. Carroll says. Denise exercised this hand and used it to help her, just as a person with two hands may use the non-dominant one to hold a piece of paper while the dominant hand writes.

Next came a trip to CPMC's brace shop to fit Denise with a brace that would strengthen the muscles in her hand. At that point, Denise could move her hand slightly. "The progress was slow," Mrs. Malangone recounts, "but every time something happened, we felt great."

Denise still did not have any fingers, just a handlike appendage. At age 10, she underwent skin grafts to form a finger. A thumb was fashioned from skin from her pelvis and bone from the side of her left leg (between the knee and ankle). Next, Dr. Carroll made the thumb movable. He took tendons from her toes and attached them to the new thumb. "She can move it down, up and out, but can't bring it in too well," says Mrs. Malangone.

Though the process at times has seemed endless, Denise's hand may be finished by the time she is 18. Denise is 12 now, and her right hand has a thumb and index finger. "If she wants more pinch later, we can help her," Dr. Carroll says. "Meanwhile, she's delighted that she can use it to hold things. This is much better than a prosthesis because she has a limb she can use and that has sensation—and she can't lose it."

Both Dr. Carroll and Mrs. Malangone agree that Denise is mostly delighted

Dr. Robert Carroll assesses the strength of hand muscles.



with her new right hand. "Everything Dr. Carroll does makes a difference," says her mother.

### Urinary Tract Reconstruction

Until recently, patients whose bladders were irreparably damaged from cancer, infection or injury would have to spend the rest of their lives tethered to a urine bag on the abdomen—a particularly debilitating prospect for people with active lives.

However, many patients no longer face that prospect. In fact, says Dr. Carl Olsson, Director of the PH Urology Service and Chairman of Urology at P&S, "We can replace the entire urinary tract south of the kidneys with spare parts from the rest of the body."

The urinary tract originates in the kidneys, then continues down narrow, 14-inch canals to the bladder, where urine collects. When the reservoir is full, its fluid is emptied through the urethra, where the tract ends.

Since the early 1980s, urologists at PH have been able to reconstruct the bladder from segments of the patient's own bowel. In addition, they can connect bladder openings where they belong, instead of creating abdominal openings to drain urine.

"We were the first hospital in the world to reconstruct a working bladder that holds urine like a normal one and place it in the normal anatomic location," says Dr. Olsson.

The new bladder is created from a two-

foot section of bowel that the patient can do well without. During surgery, this section, which is shaped like a bicycle inner tube, is split open, Dr. Olsson explains.

"We keep spreading and flattening it out from its tubular shape. Then, we sew and staple each section together until we create a sphere. In a way, it's sewn together like a patchwork quilt. When we're finished, we end up with a large reservoir." A new urethra also is made from the bowel to establish normal urine flow.

Some patients also need new control valve muscles, or sphincters, that keep the bladder watertight and prevent regurgitation of urine back to the kidneys. Surgeons can create these valves from portions of bowel that remain at the ends of the new bladder.

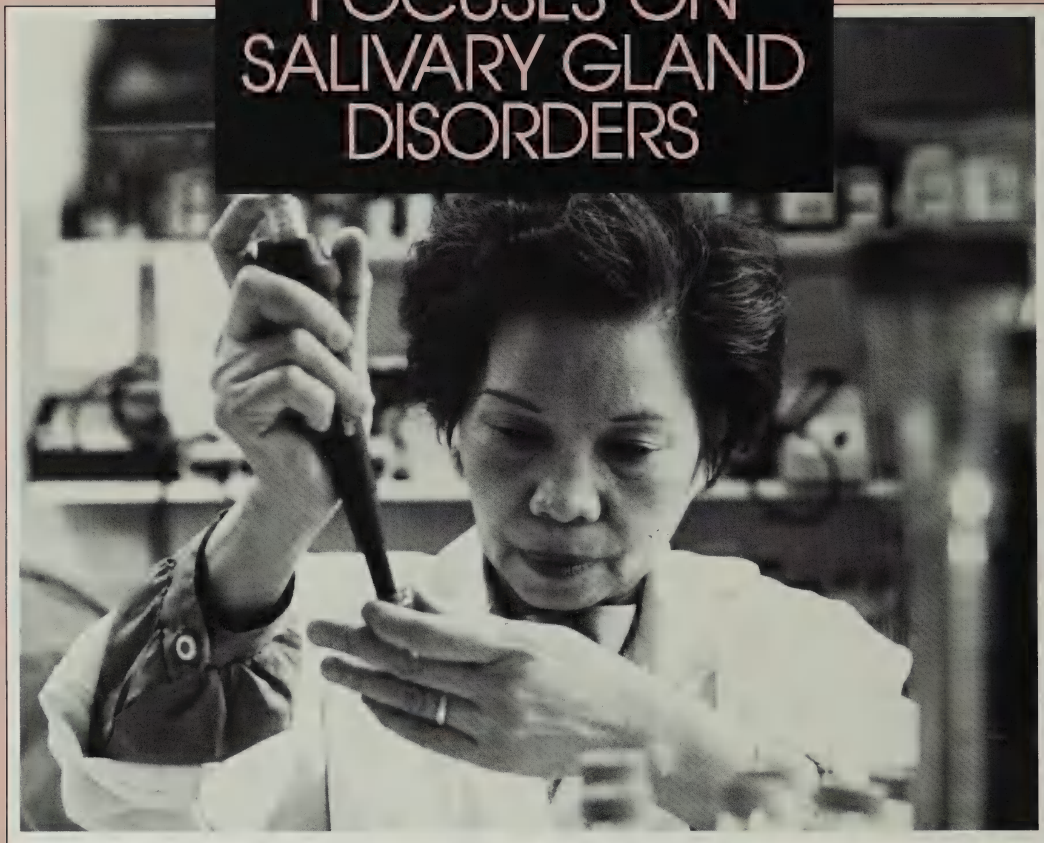
### Ureteral Reconstruction

Another urinary problem amenable to reconstruction is an irreparably blocked ureter. Physicians can remove the kidney and transplant it back into the patient's own groin. By stretching the bladder to the kidney, the two organs can be connected, bypassing the faulty ureter altogether.

"We have performed autotransplants with good results," Dr. Olsson says. "But, in some cases, these operations can be dangerous. If a risk is involved, we can take a piece of the patient's intestine and place it between the kidney and bladder, or we can fashion a new ureter from portions of the bladder itself." ■



# NEW CENTER FOCUSES ON SALIVARY GLAND DISORDERS



TARA FLANAGAN

Patients requiring specialized treatment of the salivary glands can indeed present a challenge for the physician and dentist who must make a referral. There simply aren't many facilities that focus on the complete investigation and management of salivary gland disorders.

But fortunately, that statement no longer holds true in the New York metropolitan area, which now is served by the Salivary Gland Center (SGC), a joint venture of The Presbyterian Hospital and Columbia University's School of Dental and Oral Surgery (SDOS). The Center opened in October of 1986, under the direction of Louis Mandel, D.D.S., Attending Dentist at PH and Clinical Professor in the Division of Oral and Maxillofacial Surgery at SDOS.

By offering a comprehensive service,

the SGC can verify whether a patient's problem is an extraglandular disease that closely mimics a salivary gland disorder, or if a patient is suffering from any number of conditions that affect the parotid, submandibular and minor salivary glands.

For instance, Dr. Mandel says, some patients have swellings of the masseter muscles, which tend to imitate parotid gland enlargement, caused by excessive movement of the jaw. The culprit here can be gum chewing or jaw clenching. Infected molars also can present problems that mimic glandular disorders.

Complete chemical evaluation and further research are available through the Clinical Dental Research Center, which is directed by Irwin Mandel, D.D.S. Dr. Irwin Mandel is an Attending Dentist at

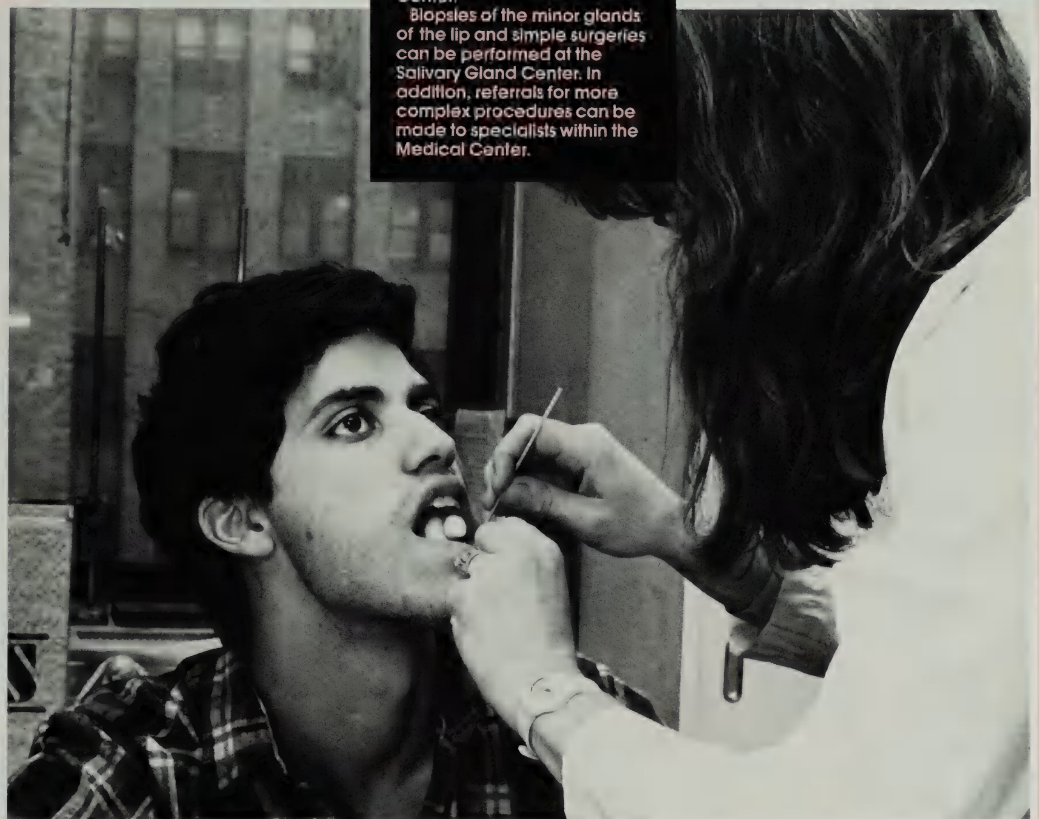
PH and Professor of Dentistry at SDOS. For more than 20 years, the Research Center has pioneered studies in salivary chemistry (including extensive work with cystic fibrosis patients) and electrolyte chemistry of hypertension patients. The Center also has developed diagnostic tests for salivary gland diseases.

Using a complete medical history, sialography (a radiopaque image of the ductal systems in the glands and other diagnostic techniques), Dr. Louis Mandel can begin to pinpoint a patient's problem. His diagnoses are enhanced by saliva volume studies and biopsies, if necessary, and confirmed by further chemical workups at the Research Center.

Where indicated, pharmacological therapy is ordered. Alternatively, the

The new Center for Salivary Gland Disorders benefits from the pioneering research in salivary chemistry conducted by the Medical Center's Clinical Dental Research Center.

Biopsies of the minor glands of the lip and simple surgeries can be performed at the Salivary Gland Center. In addition, referrals for more complex procedures can be made to specialists within the Medical Center.



TARA FLANAGAN

patient's problems may be correctable by cleansing the duct system. Biopsies of the minor glands in the lip and simple surgeries such as stone removal can be performed right at the Center, and referrals for more detailed surgeries can be made to PH otolaryngologists.

Many times, Dr. Louis Mandel says, a patient's history gives a clear indication of why he or she suffers from salivary gland disturbances. For example, he says, a patient may complain of persistent swelling of the jaw. In taking the medical history of one such patient, Dr. Mandel learned that the patient was a heavy drinker. Swelling in this case was attributed to the abnormal deposition of fat in the parotid, a common occurrence in people who drink in excess over long periods of time.

In a second case, Dr. Mandel saw a young female patient with a similar complaint. After learning about the patient's dietary habits, he confirmed that she was anorexic. Malnutrition, particularly protein deficiency, is another common cause of salivary gland complications. Both cases were confirmed by laboratory analyses.

In other cases, more detailed investigation is required. Take, for example, Sjogren's Syndrome, a fairly common autoimmune disease that results in dryness in the mouth and frequently is associated with rheumatoid arthritis. To confirm his suspicions in these cases, Dr. Mandel uses special collection devices developed at the Center that collect flow directly from either the parotid or submandibular glands. Flow studies also

are useful, he says, in distinguishing between those patients who have salivary disorders from those with psychogenic problems.

"The most common reason we see patients with dry mouths is basically because of their perceptions," he says. "It's the same thing with excess saliva."

At present, the Center is open Monday afternoons and Friday mornings, and accommodates about four patients per session. Both Dr. Irwin Mandel and Dr. Louis Mandel anticipate an increase in patients as the Center becomes established among referral networks. "We're not only a complete center for salivary gland disorders," Dr. Irwin Mandel notes, "but we're also part of Columbia-Presbyterian. That in itself makes us very special indeed." ■



# A PUZZLING DISORDER PUTS YOUNG PEOPLE AT RISK OF HEART ATTACKS



RICHARD DOWNS

Usually, we are surprised to hear of heart attack victims in their twenties, or even younger. Yet, a 25-year-old man and his 15-year-old sister who recently came to The Presbyterian Hospital from the Middle East were prime cardiac disease candidates, because of a rare disorder. In fact, their younger brother, who suffered from the same disease, died of a heart attack when he was eight years old.

The siblings both suffer from familial hypercholesteremia, a genetic condition affecting the body's ability to produce LDL (low density lipoprotein) receptors, proteins that sit on the surface of cells and remove LDL from the bloodstream. LDL is the type of cholesterol that results

in arteriosclerosis, blocked arteries and, if allowed to progress, heart attacks.

"Before they underwent treatment in their native land, their plasma LDL cholesterol levels were between 700 and 800 milligrams per deciliter (mg. per dl.)," says Richard J. Deckelbaum, M.D., Director of the Division of Pediatric Gastroenterology and Nutrition at Presbyterian's Babies Hospital division and Associate Professor in the Department of Pediatrics at P&S. The accepted normal level for LDL cholesterol is 140 mg. per dl., which equates with a total blood cholesterol of 200 mg. per dl., he explains.

Treatment with the drug cholestyramine reduced the siblings' levels to about 500 mg. per dl., a marked improvement but still far too high. Dr. Deckelbaum initiated therapy with these patients in their native Jordan and then sought to bring them to CPMC for definitive diagnosis and therapy.

Thanks to help from Royal Jordanian Airlines, the brother and sister were able to come to Columbia-Presbyterian Medical Center as patients in the Center for Clinical Research. Once the siblings arrived, Dr. Deckelbaum and Dr. Henry Ginsberg, Associate Attending Physician on Presbyterian's Medical Service and Associate Professor of Medicine at P&S, planned numerous tests and a treatment regimen with the newly available drug lovastatin.

According to Dr. Ginsberg, who also directs the Medical Center's SCOR (Specialized Center for Research in

Atherosclerosis) lipid clinic and is associate program director of the Center for Clinical Research, lovastatin is a new and promising drug that lowers cholesterol. Like cholestyramine, its final pathway of action appears to increase the body's production of the receptors that remove LDL from the bloodstream.

It is not yet available to the general public, and physicians here had to make special application for its "compassionate use" in the case of these two patients.

There are two forms of familial hypercholesteremia. In the heterozygous form, in which the inability to produce LDL receptors is inherited from one parent, patients have about one-half of the normal number of receptors, and LDL cholesterol levels run 300 to 500 mg. per dl. This genetic defect occurs in about one person in 500 in the general population. In the homozygous form of the disease, in which the genetic defect is inherited from both parents, victims cannot produce any LDL receptors and have LDL cholesterol levels of 700 to 800 mg. per dl. However, homozygous hypercholesteremia is very rare and occurs in about one person in a million in the general population.

"Actually," says Dr. Ginsberg, "we're not sure of the exact diagnosis in these two patients. Their very high cholesterol levels are typical of homozygous patients. But patients with homozygous familial hypercholesteremia don't respond to drugs like cholestyramine because they don't have the ability to produce any of these receptors. Yet, these patients have done

well on cholestyramine."

The highly sophisticated tests that Drs. Deckelbaum and Ginsberg have conducted in the Center for Clinical Research should allow them to define more sharply the nature of the patients' metabolic defects.

To these patients, this information will have more than curiosity value. In fact, when the young man arrived here, he was very depressed because of the poor prognosis associated with his illness. At one point, he actually had been told that he might as well go out and enjoy himself because his situation was hopeless. "We're trying to convince him that this is not the case," says Dr. Ginsberg.

The main thing is to get these patients' cholesterol levels down sufficiently to avert debilitating disease or heart attack in the next five to ten years. Things are moving very rapidly in the area of coronary artery disease, both in terms of new drugs to lower cholesterol and in terms of therapies available to treat disease where it exists. "The idea is to allow these patients to survive long enough to take advantage of new approaches to their problem as these therapies become available," Dr. Deckelbaum says.

Coronary artery disease is the major killer in our society, and its relation to high levels of LDL cholesterol has been clearly established. "While our primary responsibility is to help these two individuals, rare cases like these, where the disorder is so profound, offer excellent opportunities to gain knowledge that ultimately may benefit many." ■

## PEDIATRIC CARDIOVASCULAR CLINIC TO OPEN HERE

When the new clinic devoted to prevention of premature cardiovascular disease by diagnosis and intervention opens here, it will be one of only a handful of such facilities worldwide, and the only one in the tri-state area.

"In recent years, new information has indicated that identification of children at risk for early onset atherosclerosis is possible and desirable," says Dr. Richard Deckelbaum, Co-Director of the clinic and a key member of the team caring for the brother and sister hypercholesteremia patients.

For example, autopsies of 19- and

20-year-old Americans who died in the Vietnam War showed significant signs of developing atherosclerosis even at these early ages. Adults who have early onset coronary artery disease often do not have symptoms or get diagnosed until it is too late to do much to prolong their lives.

There already is substantial evidence that reducing risk factors in children or adolescents lessens the likelihood that coronary artery disease will develop later. "Most experts agree that adopting appropriate therapeutic regimens at a young age would be even more effective in deterring the disease in midlife," says Dr. Welton Gersony, Co-Director of the new clinic and Director of the Division of Cardiology in Pediatrics and Professor of Pediatrics at P&S.

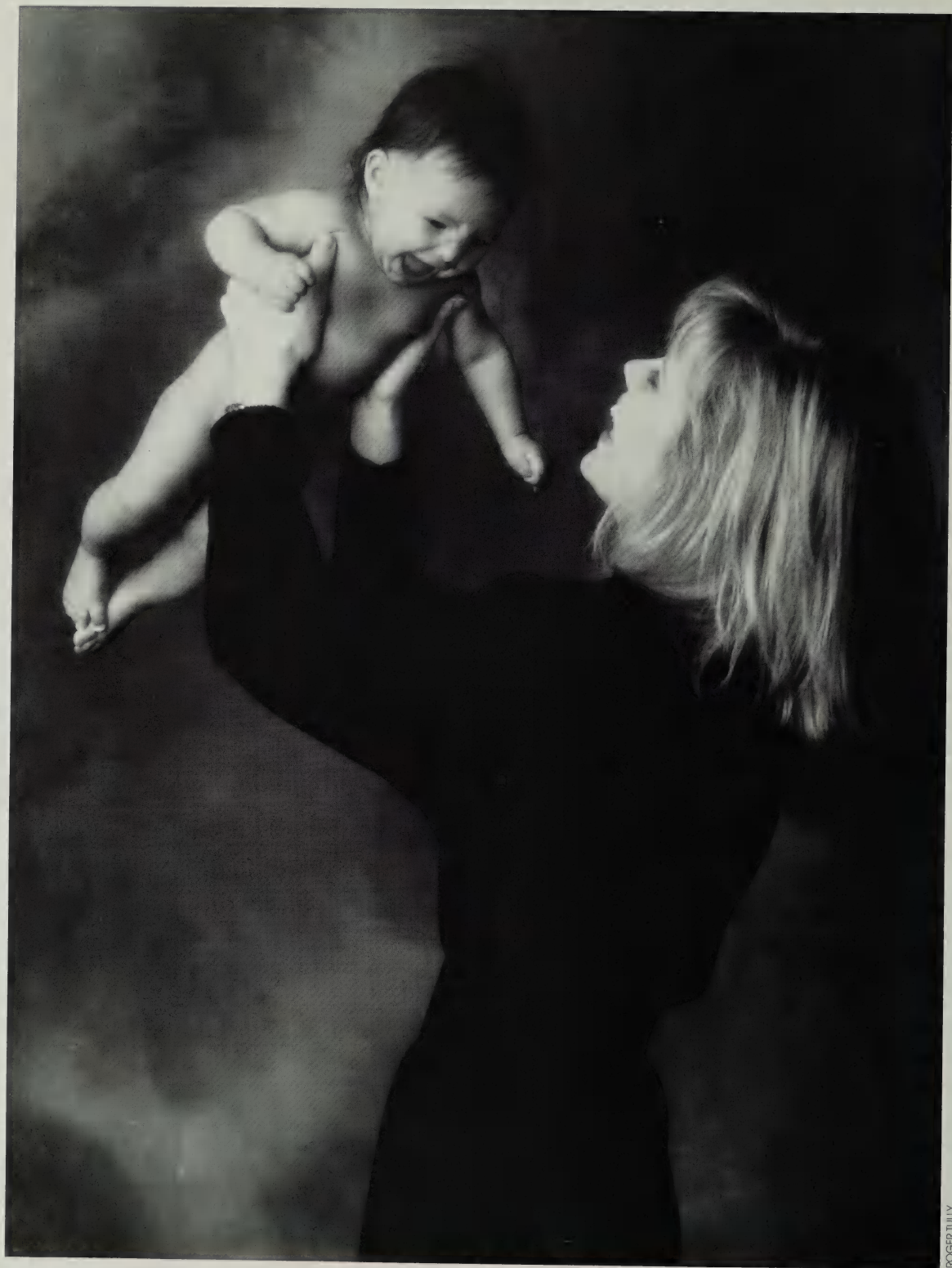
The new clinic will augment the cardiology services available to pediatric patients at CPMC, and will complement the work of SCOR by studying risk factors for atherosclerosis in children.

An important component of the new

clinic is a nutrition program supported by a recently awarded \$150,000 grant from the Donner Foundation. "Nutritional intervention is the accepted first step in combating hypertension and hyperlipidemia, the two major risk factors for premature atherosclerosis," says Dr. Deckelbaum. The clinic, which also will be staffed by a nutritionist, a physician fellow, a statistician and a laboratory technician, will serve the pediatric and teenage population of metropolitan New York, New Jersey, and Connecticut. The clinic will coordinate activities closely with the SCOR clinic.

Columbia-Presbyterian Medical Center has long been a major center for the study of lipid disorders in adults. The SCOR (Specialized Center for Research in Atherosclerosis) is one of only eight such federally-funded facilities in the country. The division of cardiology in Pediatrics likewise enjoys an international reputation, and treats young patients referred here from all over the world. ■





# NEW ADVANCE IN INFERTILITY TREATMENT HELPS COUPLES CONCEIVE

To infertile couples, this is a pregnant world. Newborn babies, strollers and expectant mothers seem to be everywhere—in every shopping mall and every supermarket line.

Now, Gamete Intra-Fallopian Tube Transfer, or GIFT, can help nearly a quarter of these infertile couples conceive for the first time. GIFT programs report a conception rate of 35 to 40 percent, almost twice that of *in vitro* fertilization.

"GIFT mimics the natural process of fertilization," says Elynn Margulis, M.D. Dr. Margulis, Assistant Attending Obstetrician and Gynecologist at PH and Assistant Professor of Clinical Obstetrics and Gynecology at P&S, directs the GIFT program. "We simply ensure that the egg and sperm meet at the right time and at the right place to allow the embryo to develop."

GIFT is actually a spin-off of *in vitro* fertilization. In *in vitro*, eggs are retrieved from the woman's ovary and fertilized with her partner's sperm; the resulting embryo matures in the laboratory for approximately two days. The patient returns to the hospital for a second procedure in which the embryo is put into her uterus, where it continues to develop.

GIFT, in contrast, requires only one procedure to aspirate the eggs, mix them with the sperm in a buffered solution and immediately inject them into the Fallopian tube(s).

"We believe that GIFT has a high rate of success because the fertilized eggs travel down the Fallopian tube, just as in natural conception. In addition," says Dr. Margulis, "since we don't interfere with

the uterus when placing the gamete into the body, the endometrial lining, which is crucial for embryonic development, is undisturbed." Another advantage of GIFT for some cultural and religious groups is its acceptability, since there is no possibility that the human embryo may develop and be manipulated before the eggs are returned to the body.

GIFT is an exacting and demanding procedure for patients and physicians. In order to stimulate the follicles, which contain the microscopic eggs, the patient takes hormones daily. A maximum of two eggs per Fallopian tube must be obtained from the woman's ovary just two hours before ovulation would occur. This timing requires extensive monitoring of the menstrual cycle by daily blood samples and ultrasound.

When an egg is "mature," it is harvested by means of a mini-laparotomy. This is a surgical procedure in which a thin catheter with a hollow needle is inserted into a tiny incision above the pubic bone, enabling the physician to identify the eggs and gently remove them. After the eggs are mixed with the sperm and introduced into the Fallopian tubes through the same incision, the patient needs only to recover from a light general anesthetic before going home. The outcome of the procedure can be determined two weeks later.

As in unassisted fertilization, the embryo may not "take," and the process of harvesting, fertilizing and transferring the egg may have to be repeated. Dr. Margulis emphasizes that GIFT and *in vitro* fertilization are not mutually exclusive and may be complementary. ■

## TRANSVAGINAL ULTRASOUND AIDS DIAGNOSIS

An important advance in ultrasound technology, transvaginal sonography, is allowing physicians to diagnose pelvic and genital problems, such as ectopic pregnancy and cancer, earlier and with a greater degree of accuracy than ever before.

Transvaginal sonography uses the same technology as abdominal ultrasound, which often is used during high-risk pregnancy to detect fetal life signs, such as heartbeat. Vaginal ultrasound generates a clearer image of the pelvic and genital tract areas than the abdominal method, since the thin walls of the vagina absorb fewer sound waves than the abdominal walls, and the genital and pelvic area organs are closer to the vaginal probe.

"We use the abdominal ultrasound to get a general view of the abdomen," says Dr. Ming-Neng Yeh, Associate Attending Obstetrician and Gynecologist at PH and Associate Clinical Professor of Obstetrics and Gynecology at P&S. "In situations like high-risk or ectopic pregnancies, we then use the transvaginal sonograph to get a clear picture of a smaller area. This enables us to better diagnose any problems that might exist."

The sonograph also can be used as an alternative to laparoscopy in *in vitro* fertilization. Egg retrieval traditionally has required a laparoscopy, involving a small abdominal incision and anesthesia, to harvest the eggs from the ovary. Now the physician can use the vaginal ultrasound both to locate and aspirate the microscopic eggs. The gynecologist inserts the probe into the vagina to find the follicle which contains the eggs and, attaching a long hollow needle to the probe, guides the needle to the eggs.

"Vaginal ultrasound makes *in vitro* fertilization faster and less painful for the patient," says Dr. Ilan Timor, Visiting Associate Professor of Ob/Gyn. "Since we don't make incisions or administer anesthesia, patients also face a shorter recovery time." ■



### Modernization & Construction Proceeding on Schedule

From mid-February through April, Fort Washington Avenue between 165th and 168th streets was closed to all traffic except patient drop-offs and service vehicles, to permit construction of skyways spanning Fort Washington Avenue that will connect the second, third and fourth floors of the new hospital building with the five-story, atrium-style court being built just north of Harkness Pavilion. The top bridge connecting the ninth floor of the new hospital with the eleventh floor of Harkness will facilitate dialogue between clinical and research faculty, thus fulfilling the objective of the original CPMC design.

One block east of the mainframe site, the \$19 million, four-story addition to Babies Hospital is well underway. By the fall, all pediatric surgery, now provided throughout the Medical Center, will be performed in the six new operating rooms at that location. Look for an in-depth look at Babies in *Stethoscope* later this year.

Three miles north, in Inwood, construction at the site of the 300-bed Allen Pavilion is progressing spectacularly as workers airlift air conditioning units into place.

The modernization program includes extensive renovation to existing buildings. On Broadway, right next to Babies Hospital, crews are



readying the site for the east energy court, an attractive, glass-encased entryway. Escalators in the lobby will provide

easy access to the major new east-west corridor stretching from Broadway to the mainframe building, uniting PH—

both renovated and new space—for the benefit of the thousands of patients who rely on our expertise.

## Comprehensive Cancer Center Awarded \$12.3 Million

The National Cancer Institute renewed a core support grant to the Medical Center's Comprehensive Cancer Center. The award totals \$12.3 million over a period of five years, and supports senior leadership and a variety of cancer research facilities maintained by the Center.

"This exciting award demonstrates the strong commitment of the National Cancer Institute to the work being conducted at our Cancer Center," says *Dr. I. Bernard Weinstein*, Center Director, Attending Physician in Medicine and Frode Jensen Professor of Medicine at P&S.

"The award will permit us to continue vital programs in basic cancer research, molecular biology, carcinogenesis, clinical research, patient care and cancer prevention."

## Nursing Conference Focuses on Organ Transplantation

CPMC staff had a major role in conducting the American Heart Association's Nurse Education Day program in April. The theme of the meeting was "Organ/Tissue Procurement and Transplantation." Among the speakers were: *John Kiernan*, M.B.A., PH Director of Organ Recovery, discussing "Coordination of Procurement and Transplantation"; and *Eric A. Rose*, M.D., Assistant Attending Surgeon and Director of Cardiac Transplantation at PH, and Assistant Professor at P&S, discussing "Transplantation."

The Medical Center also sponsored two sessions on "Sensitivity Training for Anatomical Gift Requestors." *Patricia Wrobbel*, M.A., R.N., Instructor with the Nursing Education, Research and Development Department at PH, coordinated the programs.

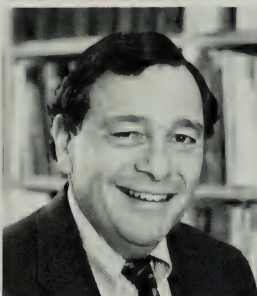
## Spring Clean-Up



Early April showers didn't completely dampen the PH annual spring clean-up. In spite of the raw, rainy April 4th day, some 50 loyal employees filled about 20 huge garbage bags with debris. Everyone agreed, though, that the day's high-

point was the barbecue lunch, with chicken, hot dogs, and plenty of hot coffee warming the diehard workers. Here, *William Vomvoris*, Director, Food and Nutrition Services (*far right*), and *John Olden*, Assistant Director, have the honors at the grill.

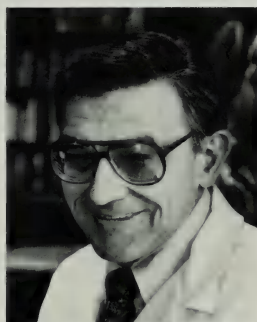
## ANESTHESIOLOGY



*Dr. Allen I. Hyman*, Attending Anesthesiologist at PH and Professor of Anesthesiology at P&S, is one of six health experts nationwide to receive a Robert Wood Johnson Health Policy Fellowship for 1987-88. Through this fellowship, sponsored by the National Academy of Sciences, Dr. Hyman will study current health issues and government policy and also will work in Washington with legislators or in the health offices of the Executive Branch on health issues.

## DERMATOLOGY

*Dr. William G. Atwood*, Assistant Attending Dermatologist at PH and Associate in Clinical Dermatology at P&S, is celebrating the publication of *Fryderyk Chopin, Pianist from Warsaw*, by Columbia University Press. The book, which covers thirty years of Chopin's career as a concert pianist, is Dr. Atwood's second work on the great composer.



*Dr. Leonard Harber*, Director of the Dermatology Service

at PH and Richard and Mildred Rhodebeck Professor and Chairman of the Dermatology Department at P&S, has been awarded the Clinical Medicine Award of the New York University Medical Center Alumni Society for 1987.

Dr. Harber also received the Pillsbury Award of the University of Pennsylvania, and, as visiting professor, presented the annual Pillsbury Lecture in Dermatology.

Dr. Harber recently returned from a sabbatical at Green College of Oxford University where he was visiting professor. He also lectured at John Radcliffe Hospital on photobiology and produced a revised edition of the landmark text, *Photosensitivity Diseases*.

## NEUROLOGY

*Dr. Norman Latov*, Assistant Attending Neurologist at PH and Assistant Professor of Neurology at P&S, participated in a symposium last year on the utility of Therapeutic Plasmapheresis for Neurological Disorders.

*Nature's Masterpieces: The Brain and How It Works* is a newly published book by *Dr. J. Lawrence Pool*, Consultant Emeritus in Neurological Surgery at PH and Professor Emeritus of Neurological Surgery at P&S. The book, published by Walker & Co., and written especially for lay readers, explores the regions of the brain and explains how they work.

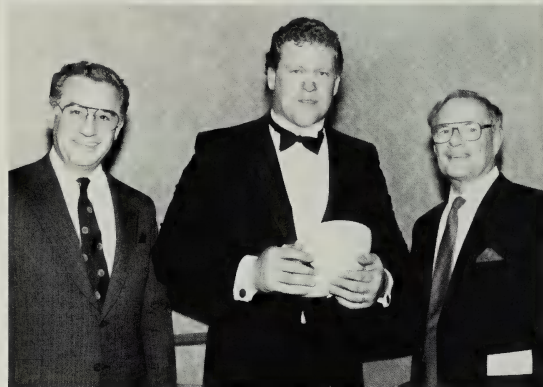
*Dr. Darryl DeVivo*, Attending Neurologist at PH and Sidney Carter Professor of Neurology at P&S, took part in two events for the Colleen Giblin Foundation in April. First, he participated in a "Toast and Roast" with honoree Brad Benson, New York Giants offensive lineman. Paul Giblin and his wife, Vicki, established the Colleen Giblin Foundation in memory of their daughter, who died of a malignant brain tumor, to further



education and research in neurology.

The second event featured Robert A. Weinberg, Ph.D.,

Professor of Biology at M.I.T., as guest speaker at the second Colleen Giblin Memorial Lecture.



Dr. Darryl DeVivo (left), with Brad Benson (center) New York Giants offensive lineman and Paul Giblin (right).



Dr. Robert A. Weinberg, Ph.D. (second from right) with Dr. DeVivo (left), Paul and Vicki Giblin and Frederick W. Alt, Ph.D. (right) Professor of Biochemistry and Molecular Biophysics at P&S, pursues research on the molecular genetics of cancer.

## NEUROLOGICAL SURGERY



Dr. Bennett M. Stein (far left), Director of Neurological Surgery, greeted a delegation of Soviet health officials at Neurological Institute this spring. Their visit was the result of a 1986 agreement to promote educational and scientific exchanges between Neurological Institute and the Burdenko Institute of Neurosurgery in Moscow.

Shown with Dr. Stein, (from left): Dr. Ivan K. Nikitin, adviser, Foreign Relations Department, Ministry of Health; Dr. Oleg P. Schepin, First Deputy Minister of Health; Dr. Ted Mala, University of Alaska; Dr. Robert H. Holtzman, Clinical Professor of Neurosurgery, Downstate Medical Center; and Dr. Leonid Yudin, Counselor of Medicine, U.S.S.R. Permanent Mission to the United Nations.

## OTOLARYNGOLOGY

"Dangers of Noise and Ways to Quiet Your Community" was the topic of a lecture presented by Dr. Thomas Fay, Director of Speech and Hearing at PH. He spoke at a conference on noise pollution sponsored by the Council on the Environment of New York City and the Kingsborough Community College.

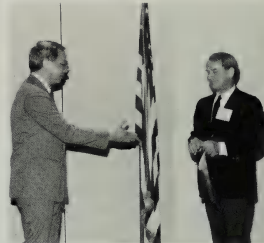
## OBSTETRICS/ GYNCOLOGY

OB/GYN welcomes Dr. Daniel H. Smith as Director of Gynecologic Oncology. Dr. Smith, Assistant Attending Physician at PH and Assistant Professor of Clinical OB/GYN at P&S, graduated from Harvard Medical School and completed his residency at Massachusetts General Hospital. He comes to CPMC from Memorial Sloan-Kettering Cancer Center and Cornell University-New York Hospital.

## ORTHOPEDIC SURGERY

Dr. John R. Denton, formerly Associate Attending Orthopedic Surgeon at PH and Associate Clinical Professor of Orthopedic Surgery at P&S, has been named

Director of Orthopedic Surgery at the Catholic Medical Center of Brooklyn and Queens.



Dr. Harold Dick cut a ribbon to mark the opening of a new orthopedic research laboratory in April. Dr. Van C. Mow, Professor of Mechanical Engineering and Orthopedic Bioengineering, will direct the new lab, which features state-of-the-art biochemical instruments, bioengineering material testing equipment and computer systems which can be used to analyze the material properties of cartilage and develop man-made materials to replace damaged cartilage. The laboratory, which has been funded by a major grant from the National Institutes of Health, is conducting research on osteoarthritis. Following the ceremony, Dr. Mow gave a tour of the lab's facilities to visiting scientists from NIH.



Dr. Mow with visiting scientists from NIH, conducting a tour of the lab's facilities.

## CPMC CONSULTATION/ REFERRAL SERVICE

The Columbia-Presbyterian Consultation/Referral Service can help you find an appropriate CPMC physician. For information, call (212) 305-5156.

## PSYCHIATRY

*Dr. Alexander Glassman*, Attending Psychiatrist at PH and Professor of Clinical Psychiatry at P&S, chaired the American Psychiatric Association's task force appraising the value of the dexamethasone suppression test (DST). The panel concluded that DST has limited value in psychiatry.

The report, based on 10 years of published research on DST, will be published in the *American Journal of Psychiatry*.

*Dr. David Shaffer*, Attending Psychiatrist at PH, has been named Irving Philips Professor of Child Psychiatry at P&S. The new professorship was created by a \$1 million gift from the Jesse Philips Foundation in the form of a two-for-one matching grant. *Dr. Irving Philips* is a child psychiatrist at the University of California at San Francisco. *Dr. Shaffer* (at right), shown with *Dr. Irving Philips* (far right), who also is Director of Child Psychiatry at PH, P&S, and the New York State Psychiatric Institute, serves on both President Reagan's and Governor Cuomo's Commissions on Prevention of Youth Suicide.



## SOCIETY OF PRACTITIONERS



The Society of Practitioners honored *Dr. Edgar Leifer*, Consultant in Medicine at PH and Professor of Clinical Medicine at P&S, as Practitioner of the Year at a gala dinner in April. *Dr. Leifer*, a specialist in internal medicine, served as Director of Medical Affairs for the

Hospital from 1977 to 1983. Shown above, (from left): *Henrik H. Bendixen, M.D.*, Columbia University Vice President for Health Sciences; *Felix E. Demartini, M.D.*, former president of PH; *Dr. Leifer*; *Thomas Q. Morris, M.D.*, PH President; *Alfred Markowitz, M.D.*, Attending

Surgeon at PH and Professor of Clinical Surgery at P&S; and *Michael Wechsler, M.D.*, President of the Society, Assistant Attending Urologist at PH and Assistant Clinical Professor of Urology at P&S.

## UROLOGY



*Dr. John Kingsley Lattimer*, Consultant in Urology at PH and Professor Emeritus of Urology at P&S, has received the first Award in Urology, presented by the National Kidney Foundation in recognition of his lifetime achievements in the field.





The Presbyterian Hospital  
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New York, New York 10032-3784

Spare parts  
surgery can restore  
muscles in hands and  
other parts of the body.



# Stethoscope





TEACHING MOTHERS  
ABOUT GOOD HEALTH

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PROTECTING THE CHILDREN  
WHEN PARENTS CAN'T COPE

6

A publication of  
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Columbia-Presbyterian Medical Center  
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## THE BUCK STOPS HERE

"In this community of our clinics and hospitals, some of the ideals mankind today most earnestly debates and strives to reach are quietly achieved through the twenty-four hours of every day. Here, where the dominant interest of each is to give or to find healing, concern varies only with the need for care without regard to race, creed or color or politics or wealth... And here almost unnoted the spirit of mutual respect and good will prevail among the 'multitudes brought hither out of many kindreds and tongues'."

Those words were taken from The Social Services Annual Report of 1946 (Social Services was already well established by the time the Medical Center was founded in 1928), but they could have been written yesterday. In 1946, the Hospital had a role in helping the nation recover from the traumas of war; today, Presbyterian has a role in improving the lives of some of this society's most vulnerable people: homeless infants and adults; AIDS patients; those afflicted by other catastrophic illnesses or injuries; often-forgotten crime victims; depressed and suicidal youths.

The problems have changed, yet the goals remain the same: "to give or find healing." These goals are met on an individual level, by providing outstanding medical care and emotional support for some of this society's most vulnerable people. And they are met on a far wider level, as Hospital leaders work with other community and government leaders to make sure they remain aware of and responsive to patients' socioeconomic needs.

"People look to Presbyterian as a community agency that has both power and compassion," says Esther Chachkes, Presbyterian's Director of Social Work Services. "It is up to us to make sure that all of our patients, whether rich or poor, have access to all the services they're entitled to, to keep agencies 'honest' and to fight 'Woody Allen' bureaucratic foul-ups."

This issue of *Stethoscope*, "America's Social Policy: The Buck Stops Here," examines some of the ways The Presbyterian Hospital addresses the social problems that affect patients—people who often rely as much on our compassion and ability to care as on the clinical services we provide. ■








# TEACHING *Mothers* ABOUT GOOD HEALTH

Latchkey children, teenage mothers, low-income, single women who head households, and a high divorce rate are all signs of family problems that are endemic to our society. Washington Heights/Inwood has the highest birth rate in New York City. In light of this high birth rate, together with cutbacks of government funding and Presbyterian's responsibility as the only hospital in the area, the Hospital has initiated or become involved in a number of programs in family and child health care.

"In recent years," says Esther Chachkes, Director of Social Work Services, "social policies in this country have been predicated on a philosophy that the family, not government, should carry the full





responsibility for all of its members.

"Most of the families we see cannot carry that burden," she continues.

"These families are poor, and sometimes they include aging parents as well as young children. They are heroic in what they deal with as it is, but they are overburdened with multiple problems."

One program, Women, Infants and Children (WIC), aims at giving its clients—mothers and their infants—the basics of sound nutrition by providing them with supplemental foods and nutrition education, in both Spanish and English.

### **Trying to Beat the Odds**

Women (you'll see no men except for one member of the office staff) come to the WIC office hoping to beat the increasing odds against inner city babies. Because of tight federal and state budgeting, the WIC office can help only 1,500 of an estimated 60,000 eligible Washington Heights/Inwood residents, and only children with extraordinary risks of disease and malnutrition are accepted into the program. The ones who are accepted must be weaned from WIC at age two to make room for more.

At a glance, WIC might appear to be a stop-gap measure that gives needy families a brief respite before abandoning them to their original predicament. But because of the Hospital's involvement and the WIC staff's commitment to its clients, there is hope.

About 95 percent of the women and children enrolled in WIC come to The Presbyterian Hospital for health services. That's not to say they always come often enough or that the Hospital can meet all their socioeconomic needs, but it does mean that when they visit the Hospital, they can connect with help.

Referrals to the WIC program come from Hospital nutritionists, social workers, and clinic staff who see the need for patients to get help beyond that provided by the welfare and food stamp programs.

### **Expanding to Meet People's Needs**

In response to the need to serve greater numbers of mothers and infants, the WIC office soon will relocate to a site in the neighborhood, enabling the program to double its client load. The staff of five will become nine, who will be paid by the Hospital and through a grant from the New York State Department of Health.

Just as the Hospital brings patients to WIC, the program introduces other Hospital services to its clients who are not taking full advantage of available resources.

"We're the eyes of the community," says Carol Peirce, WIC Program Director. "What we do here goes far beyond feeding the poor. Besides, WIC isn't a food handout—it's intended to be an adjunct to preventive health care."

### **Involving the Entire Neighborhood**

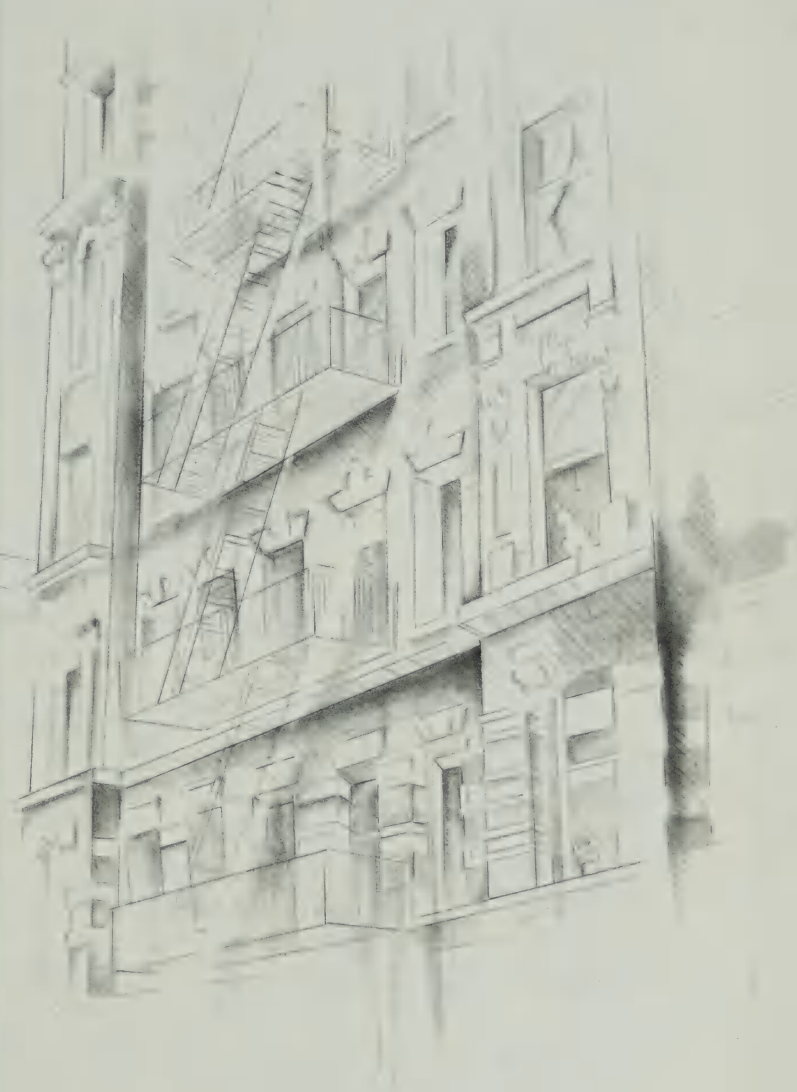
Ms. Peirce, a registered dietitian, finds herself working far beyond the bounds of her original vocation. One day she'll meet with representatives who teach neighborhood grocers how to use the WIC voucher system, whereby women exchange coupons for prescribed food packages. Sometimes she will visit neighborhood stores to ensure they are providing fresh, safe products for her clients.

She and her staff spend hours connecting women with Hospital programs such as breastfeeding classes and family planning. WIC encourages its mothers to take advantage of well baby visits, which provide regular health maintenance rather than sporadic jaunts to the emergency room, which, unfortunately, account for the majority of the health care measures taken by poor people in Washington Heights/Inwood.

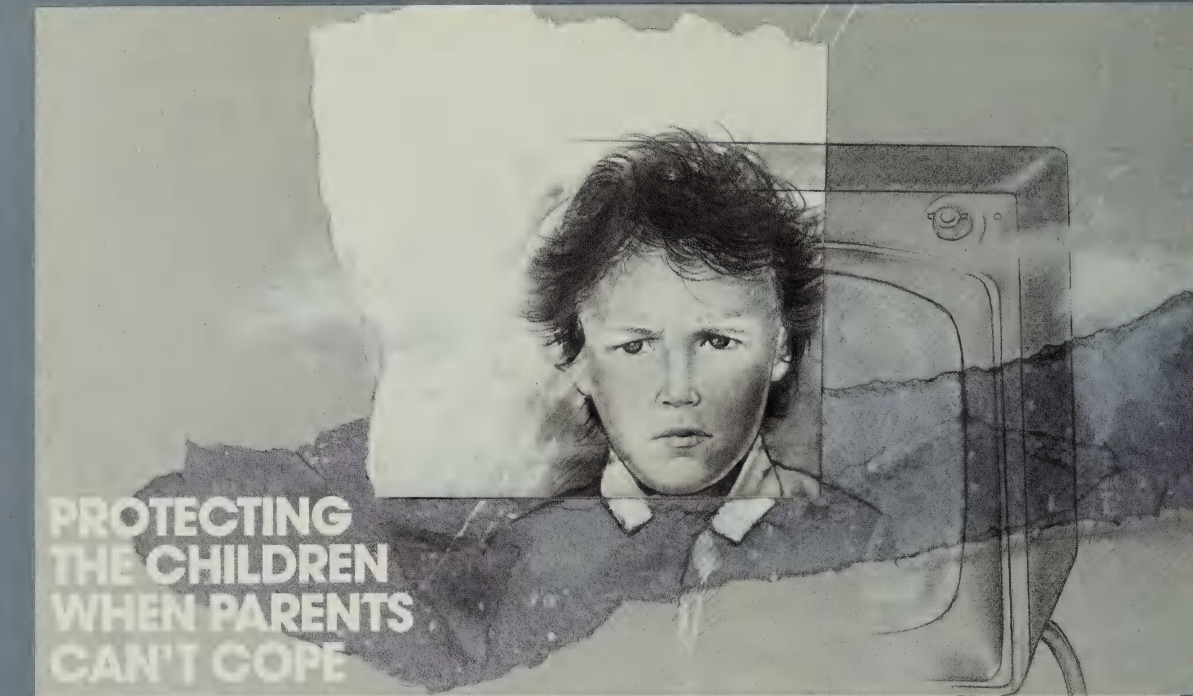
Through Operation Baby Track, run by the Red Cross at the Hospital, WIC parents can receive information and follow-up on childhood immunizations. At the Hospital's Therapeutic Nursery, bilingual WIC nutritionists provide nutrition information to parents of physically disabled or emotionally abused or neglected children, teaching them the basics of food and nutrition.

Ms. Peirce also must anticipate the time when her clients leave the program. Therefore, WIC reintroduces its participants to job training and employment opportunities, if appropriate, and teaches them how to stretch their sparse food dollars. Nutritionists, well versed on the cultural eating habits of the neighborhood's diverse population, work with clients to help them improve their menus without losing their ethnic flavor.

"You can't work with a person in just one area of her life and expect to make a big change," Ms. Peirce says. "So in a short time, we try to teach everything we can. With the Hospital's help, we can connect people, and help make some lives better." ■







## PROTECTING THE CHILDREN WHEN PARENTS CAN'T COPE

**WHAT KIND OF PARENTS ABUSE THEIR CHILDREN?** It's easy to think of them as "monsters," different from the rest of us. But many child development experts believe that they are not so dissimilar. These parents are average people with above average problems, and few skills with which to solve them. Chances are, they have one or more problems that put them at higher risk for abusing their children, such as poor social skills, little education, financial pressures, a broken home, or a drug or alcohol problem. As the list grows, so does the chance that they will maltreat their children.

Dr. Nicholas Cunningham, Attending Pediatrician and Director of the Division of General Pediatrics at The Presbyterian Hospital, says, "I see child abuse as part of a continuum, as something people fall into the habit of doing because they have inadequate support systems or because they are acting out what was or is now being done to them.

"All parents can use extra help," he adds. "When you have that first child, your life is turned upside down. On the one hand you fall in love with the baby, and on the other, the baby disrupts your life in a way much beyond the imagination of most of us. So there's love, anger, and resentment—and everyone can use help."

The prevalence of cocaine (and its

more potent, highly addictive form, crack) has greatly exacerbated the problem of child abuse in major urban areas. As Dr. Cunningham explains, "The single thing that characterizes the maltreating family is isolation. Cocaine also isolates you, especially from the people who would normally be supportive—your parents, friends, and relatives.

"People can't serve two masters," adds the pediatrician, who also is Professor of Clinical Pediatrics at the Columbia University College of Physicians & Surgeons and Professor of Clinical Public Health in the School of Public Health. "The mother may be attracted to her child, but possibly her attraction to a very addictive drug outweighs other attachments."

### Detecting Child Abuse

Child abuse assumes many forms. Children are physically harmed, medically neglected, sexually molested, and emotionally tormented. Much abuse is difficult to detect because of the lack of physical evidence.

Health care workers at Presbyterian and its Babies Hospital Division encounter abused children in the emergency room, the various pediatric clinics and, sometimes, on the inpatient floors. Often, abused children are brought in for treatment by the Office of Special Services for Children (SSC), the agency that

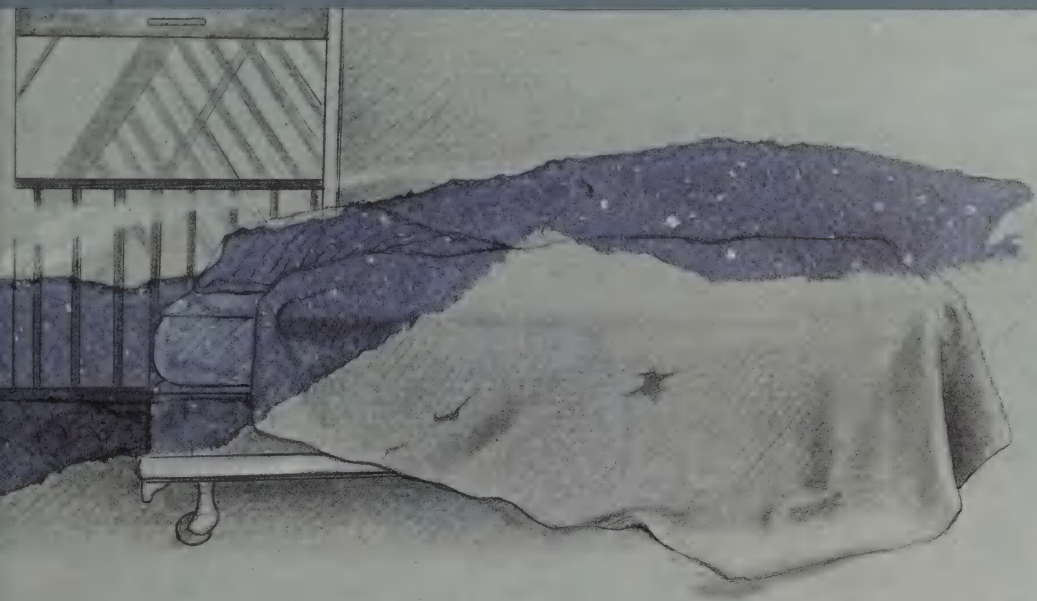
oversees child welfare in New York City. But many cases of abuse are first discovered by PH's pediatricians, social workers, and nurses, when children come in with injuries that don't match their parents' explanations, or with injuries that smack of maltreatment, such as burns in the shape of an iron.

Every case of actual, suspected or potential child abuse is reported to Susan Bardfield, Administrative Assistant of the Child Protection Program in PH's Department of Social Work Services. As long as the child remains in the Hospital system (either as an inpatient or an outpatient), Ms. Bardfield or her co-workers monitor the case, making sure follow-up appointments are kept and appropriate care is delivered.

In total, says Doris Gilestra, Social Work Supervisor for Pediatric Psychiatry and the emergency room, the Hospital receives about 45 to 50 child abuse reports each month.

Ms. Bardfield, in turn, reviews the reports of all child abuse cases and makes sure they are reported to SSC, which, in conjunction with PH staff members, determines what action will be taken. Basically, there are three options:

- Sick or injured children may be admitted to the Hospital.
- If the potential for further child abuse is high, SSC may temporarily place the child with a relative or in a foster home.



□ If the potential for further child abuse is low, the child may go home with the parents, but with an appointment for medical and social work follow-up.

Within 24 hours of receiving a child abuse report, SSC must send a case worker to meet with the family and assess the home environment.

"We don't like to remove the child from the parents unless it is absolutely necessary," says Dr. Cunningham. "The foster home system isn't working very well. Some of the children are so aggressive that they elicit abuse even in a new home."

Thus, many children are sent home with their parents, but usually with certain constraints. For example, SSC may require the parents to attend a drug rehabilitation program, or to bring their children in for regular checkups, or to attend, perhaps with their children, special counseling programs. If the parents fail to do so, SSC can take the case to court and have the children removed from the home.

#### **A Nursery for Parents and Children**

One of the most progressive child abuse programs in the country is PH's Therapeutic Nursery, which, despite its name, is for both parents and children, from infancy through age five. (PH also has a program for older children called

the Family Center.) Unusual for a hospital program, it deals exclusively with child abuse and neglect.

"By the time we get these cases," says Dr. Cunningham, the Nursery's Administrative Director, "the problem is chronic. So it requires a lot of therapy and intensive effort. Families come in from two to four times a week, for maybe a year or two, or three."

Treatment at the Nursery has a three-part focus. According to Dr. Cunningham, "There are three patients in child maltreatment: the parents, the children, and the relationship among them. That's why it's a multidisciplinary effort."

The key to the program, according to Wendy Kamaiko, the Nursery's Associate Director, "is that we set up a very warm and nurturing environment. Many of our patients come from very deprived homes."

To improve the parent-child relationship, the families meet in one of several groups, depending on whether the children are infants, toddlers or preschoolers (some sessions are run in English and in Spanish). Often, the sessions involve simple activities, such as a shared meal, finger painting, or a trip to the carousel in Central Park.

The idea is for the parents to get "some spark of pleasure from their children," says Ms. Kamaiko, who has a

background in both early childhood special education and family therapy. "Many of our parents have gotten very little pleasure from parenting. They're depressed and needy, and their children are demanding of them. We delight in the kids ourselves, and you see the mothers do a double-take. It makes them reassess."

#### **Combining Individual and Group Therapy**

After the parent-child sessions, the parents might meet for group psychotherapy while their children receive individualized treatment from child development specialists.

The parents also have individual psychotherapy, an innovative aspect of the Nursery. Though the actual physical abuse by the parents stops immediately (because if the abuse continues, the child is removed from the home), other problems are more entrenched.

"Very few parents admit to having abused their children," explains Ms. Kamaiko. "It takes a lot of ego strength to admit such behavior and feeling. So you appeal to the parent on another level, for example, by saying, 'What happened to your child is serious. You're concerned and worried about what happened, and so are we. We have to work together to make sure this



"MANY OF OUR PARENTS HAVE GOTTEN VERY LITTLE PLEASURE FROM PARENTING... WE DELIGHT IN THE KIDS OURSELVES, AND YOU SEE THE MOTHERS DO A DOUBLE-TAKE. IT MAKES THEM REASSESS."

never happens again'.

"Many of the parents were themselves victims of child abuse or spouse abuse," she adds. "We are saying to them, in effect, 'Have an intimate relationship with me. Tell me what you are thinking and feeling and we will respond appropriately with care and understanding.' But we have to prove ourselves as trustworthy. Usually, it's only after six months that you begin to see some improvement."

The health care workers also have to fight the image of being part of the "system." Many families are required by the courts to attend the program. "They are so caught up in fighting the system that they again feel victimized. Sometimes we fight them all the way to the end of the court mandate, when we say, 'Now you know what we're all about. You don't have to come, but how about coming because you want to?' The parents generally do."

The staff tries not to tell parents what to do. "We want to teach them, not simply to listen to us, but, more important, to learn problem-solving skills they can use on their own," says Ms. Kamaiko.

### Watching Children Change

The children tend to change much more rapidly than the parents. "We've been able to place many children in normal classrooms. A number of the children have gone on to the Medical Center's nursery school. It's very exciting—these kids were originally slated for special education because of their behavior problems and language delays," Ms. Kamaiko says.

Families are free to come and go from the program, assuming the court man-

## PREVENTION: THE MISSING ELEMENT

Though treatment for abused children and their parents is crucial, Dr. Cunningham and his colleagues believe it is not enough. "We ought to be thinking more preventively, so we have proposed that the Hospital organize a kind of parenting center where we would try in the perinatal period to identify parents who might need extra help.

"In the past, mothers would come in and have their babies and we didn't get to know them very well. Now, we've got approval from the Hospital to hire a couple of nurse-practitioners who will do most newborn physicals, and do them in the room with the mother. It's a perfect time for the PH staff to learn about the parents, their anxieties, their plans, and their support systems.

"We would like to use that information," Dr. Cunningham continues, "together with prenatal information gathered by midwives and obstetricians. We would then give the parents

date has ended. "We have a hotline," says Dr. Cunningham. When the parents get out of control, we want them to call us rather than lash out."

The centerpiece of the Therapeutic Nursery's busy quarters on Babies Hospital's sixth floor is the Family Room (waiting room), which is filled

appointments to come back for group sessions, where they could see videotapes of good parenting behaviors and seek counseling. And we could encourage such things as breastfeeding."

Dr. Cunningham stresses that the Medical Center is the perfect place for a parenting center. "An institution like Columbia-Presbyterian, with excellence in all areas—nursing, social work, pediatrics, psychiatry, psychology—and a general research-teaching environment, is particularly appropriate for dealing with such high-risk families. Our feeling is that the basic science for this has not yet been developed. We need a place where we can look at what we do and evaluate it."

Many related research projects already are being planned or are in progress. One project calls for videotaping all families when they first enroll in the Therapeutic Nursery and again at regular intervals to see if such visual records help health care workers document behavioral change more objectively. Another project is examining whether carrying babies in soft carriers helps mothers form a bond with them. "Infant carriers are a potentially valuable tool for promoting the love affair between the mother and the baby," says Dr. Cunningham. "We are now working with preemies, who are at particularly high risk for maltreatment." ■

with toys, a fish tank and big overstuffed couches. It's a welcome refuge for both parents and kids, who spend much of their lives waiting for all sorts of social services in less-than-comfortable surroundings. At any given time, about 50 to 60 families are enrolled in the Therapeutic Nursery. ■

**"WE TRY NOT TO TELL PARENTS WHAT TO DO. WE WANT TO TEACH THEM NOT SIMPLY TO LISTEN TO US, BUT, MORE IMPORTANT, TO LEARN PROBLEM-SOLVING SKILLS THEY CAN USE ON THEIR OWN."**

## BOARDER BABIES: THE YOUNGEST VICTIMS

Some children are victims of abuse before they are born. The abuse usually comes in the form of alcohol and drugs, and most often cocaine, which the mothers take while pregnant. The drug eventually makes its way into the fetal bloodstream, with an effect as potentially damaging as physical abuse or medical neglect.

"Cocaine tends to decrease the supply of blood to the uterus," says Cynthia McKie-Addy, Nursing Care Clinician for Babies Hospital 7 South. "Thus, many babies are born small for gestational age or premature," which leads to many health problems.

Substance abuse is detected through a blood test. Any baby whose toxicology report is positive for illegal drugs is automatically reported to Special Services for Children and discharge is deferred, at least until the home environment has been assessed. Because many of these mothers are chronic drug abusers, unwilling or unable to reverse their ways, many of these babies are placed in foster care homes.

If the foster care system were working

well, the babies could be placed in homes right after they are medically cleared. Ever since crack hit the streets, however, an already overburdened foster care system has become backlogged in placing many of these infants. Earlier this year, about 300 so-called boarder babies were living in city hospitals, some for several months. Fortunately, reports Ms. Gilestra, SSC recently stepped up its placement efforts, lowering the numbers and average length of stay of boarder babies.

On any given day, PH is home to about 10 such babies. The average stay now is about two weeks. Some babies, especially those with physical or mental handicaps, are extremely hard for the city to place and therefore they stay in the Hospital for months.

"Right now, we have a baby who was born premature and hydrocephalic. He will be one year old in September," says Marie Gucciardo, Social Work Supervisor for Pediatrics and Obstetrics.

For each boarder baby, SSC pays for the first 10 days of care, after which the cost is borne by Medicaid or more often by the Hospital.

### **Creating a Home-like Setting**

Hospitals are, to no one's surprise, not the best places to raise healthy babies. PH's nurses, doctors, and social workers, however, have made the best of a bad situation.

"To make sure the babies achieve their normal development phases, we try to create as much of a home-like atmosphere as we can," explains Ms. McKie-Addy, whose floor is home to the remaining boarder babies. "So we dress the babies in regular clothes and have many stimulating toys, such as

music boxes and mobiles. We're really committed to preventing the babies from just lying in the cribs. We talk to them and play with them, and take them out to the garden." Foster grandmothers help out as well.

Some of the mothers never visit their babies; others visit regularly. "We try to teach them about infant care, but there's room for more programs to teach about parenting. And we need to educate people about cocaine, and that it does affect the baby," says Ms. McKie-Addy.

Understandably, the staff gets very attached to these babies; some even want to adopt them. "When they go back to their mothers it's easier—if they have good support—because you see a family reunited," she adds. "But when they go into foster care or a group home, it's disappointing. You don't know if they are going to get the same time and attention and love."

### **Advocating for Children**

"This is one of those problems people would like to sweep under the rug," says Dr. Cunningham, Director of the Division of General Pediatrics. "These are poor babies. Our society seems to tolerate less than adequate care for them. We put mothers and babies in welfare hotels and other places that are grossly inadequate, and yet we act as if that's okay."

"Well, I don't think so. We have to do some advocacy work. There's going to be a rise in infant deaths or various complications, or the children are going to be maltreated—and we won't know about it for a while." Dr. Cunningham has contacted legislators concerning ways to keep families united while offering necessary medical care and counseling. ■





THE HOMELESS, with their bags and ragged clothes and cardboard coffee cups offered for spare change, have become a familiar sight. But there is a difference between the homeless of the 1980s and those of other eras.

"We began seeing great numbers of homeless again in the 1960s, when government policies started to favor deinstitutionalization of mental patients," says Esther Chachkes, Director of Social Work Services.

"Many of these people are unable to cope with daily life and have no support systems. Add to the mentally ill, drug abusers and homeless families, and you have an entire class of permanently homeless people."

Medical problems often seen among the homeless include tuberculosis, hepatitis, and AIDS. In a sense, the homeless are fortunate when they are admitted as inpatients to the Hospital, since often they do not receive adequate medical or follow-up services when they live on the streets or even in shelters.

"Ironically, before they connect with a hospital, they may never come in contact with any professionals who can help them. We try to find some kind of living arrangement for them," says Ms. Chachkes, "perhaps with a relative or in a nursing home. But sometimes, there simply isn't an alternative for a homeless person other than the shelter system, inadequate as it is."

### Helping the Most Hopeless

The Hospital's Psychiatric Shelter Program for mentally ill homeless men was created to reverse the pattern of homelessness for some of the seemingly most hopeless psychiatric patients.

"Chronically ill homeless patients often don't respond to traditional psychiatric approaches," Says Jeff Grunberg, Director of the Psychiatric Shelter Program. "These people are known for just disappearing from their treatment programs. So first we try to motivate them to stay with the program, to feel that we accept them as they are; down the road, we can work on their emotional defenses and problems and figure out how to handle them."

## FIGHTING PERMANENT

# HOMELESSNESS

When he entered the shelter in the spring, Jack LaValle (not his real name) was immediately identified as a perfect candidate for the Program; not only was he homeless, but he also was mentally retarded. From age four until he was 21, he had been placed in various foster homes and a residence for retarded children. When he was 21, attempts were made to place him in a community residence program, but he could not adjust to the rules and regulations. He became demanding and then aggressive, throwing chairs and tantrums. Finally he was hospitalized.

After another series of unsuccessful placements, Jack wound up in the city's shelter system. After several months, he was referred to the Psychiatric Day Program, and has been attending

faithfully for several months.

At first, Jack was distrustful of the program staff and behaved explosively, threatening both to commit suicide and to kill staff members. Over time, staff helped him learn to control his behavior and develop friendships with other men in the program.

"Jack agrees with us that what he needs now is an adult foster home," says Ralph Robertson, M.S.W., Clinical Coordinator. "He didn't do well in psychiatric hospitals or residences in the past. He may need the support and attention that a specially structured home environment can provide. The problem is that resources are scarce and waiting lists are long.

Once a program participant is placed, he is encouraged to keep in touch with

friends and staff from the program. He also can be followed for up to three months by staff.

The Psychiatric Shelter Program was made possible through a contract with the New York City Department of Mental Health, Mental Retardation, and Alcoholism Services. "This program is a whopping success," says James C. Rice, Assistant Commissioner of the Department. "It is achieving its goal of rehabilitating people so that they can move from the shelter system to other supportive residences."

"We know we're a small program," Mr. Grunberg says, "but if we succeed we may point the way toward finding a better life than the streets or shelters for a group of people who really have been forgotten." ■



# STRAIGHT TALK FOR TROUBLED TEENAGERS

**Approximately 2,000 15- to 19-year-olds and 200 adolescents under 14 kill themselves every year in the United States. In the last 30 years, the suicide rate has more than doubled for boys and increased 30 percent for girls. Experts report at least 100 attempted suicides for every completed one.**

As suicide numbers rose, psychiatrists, psychologists, and social workers at The Presbyterian Hospital recognized the need for intervention. A grant from the Ira DeCamp Fund enabled the Hospital to open the Child and Adolescent Depression and Suicidal Disorders Clinic in 1984.

"We had identified many children who needed this kind of care through our child depression research at The New York State Psychiatric Institute," says Dr. William J. Chambers, Director



"They have no idea of the seriousness of what they're doing. They don't realize that certain commonly available pills can kill them."

"Ten to 50 percent of the teenagers who take an overdose will take another one within the year," adds Dr. Trautman. "They try to commit suicide to change a social situation. A short-term improvement often occurs after a suicide attempt, but things soon revert to the original situation. If the suicide attempt was effective, meaning that it won attention and sympathy even in the short run, the child is likely to try again. Further attempts increase the risk of death."

School guidance counselors and parents often call Miriam M. Gonzalez, C.S.W., Crisis Coordinator for the Pediatric Psychiatry Clinic, to report a suicide attempt. Once the teenager arrives, Ms. Gonzalez interviews the

teenager, assesses the severity of the situation, and provides referrals for further treatment.

...the risk of... suicide attempt... Clinician... to report...



them." David Shaffer, M.D., Director of the Division of Child and Adolescent Psychiatry, Madelyn Gould, Ph.D., an epidemiologist at Psychiatric Institute, and Paul Trautman, M.D., Director of the Child and Adolescent Depression and Suicidal Disorders Clinic, conducted that research with Dr. Chambers.

Today, social workers, nurse clinicians, psychologists, and psychiatrists staff the Clinic, the Crisis Service and the Consultation-Liaison Service—the three components of the teen suicide program. The Clinic is part of Pediatric Psychiatry and is located in Babies Hospital, Presbyterian's children's hospital.

### High-Risk Teenagers

Although the popular stereotype of a suicidal teenager is a depressed, anxious, self-critical overachiever, youngsters attempt suicide for a multitude of reasons. Certainly, many of those attempting suicide are depressed.

A large number are aggressive rather than withdrawn, with histories of behavioral problems, difficulty getting along with others, drug and alcohol abuse, and antisocial behavior, according to Dr. Trautman. Groups at high risk for suicidal behavior include psychotic children, homeless and runaway youths, teenaged mothers, and children with chronic illnesses.

"They come from homes with a lot of parent-child conflict," Dr. Trautman says. "These kids also see their parents fight with each other. Sometimes the parents themselves are mentally ill."

Dr. Trautman describes the typical teenage suicide attempt: a disturbed adolescent takes an overdose of pills as an impulsive act after an argument with parents or a girl- or boyfriend. "The overdoses are more often taken out of anger than sadness," he says.

Although the number of pills and the risk to health often are not high, these attempts are dangerous because the kids act impulsively," says Dr. Trautman.

## "NEVER AGAIN... IT'S NOT WORTH IT"

A few months ago, Natalie Nelson (not her real name), 14, had an argument with her grandmother. As the two shouted at each other, Natalie's mother reached out and slapped her daughter's face, hard. "I got mad," recalls Natalie, "so I swallowed all of my asthma pills at the same time."

Natalie could have become a statistic in the rising rate of suicides among American teenagers. Fortunately, she was found and brought to The Presbyterian Hospital, where she was treated and referred to the Child and Adolescent Depression and Suicidal Disorders Clinic at Presbyterian's Babies Hospital Division.

"I didn't think the pills would harm me," recalls Natalie. "I just wanted to scare my mother and grandmother."

Natalie had a 14-year-old friend who swallowed a bottle of sleeping pills after she argued with her mother about a boyfriend. The teenager slept for three days and never sought treatment at all.

The Clinic looks at teenage suicide attempts in the context of the entire

family and, if possible, involves the family in treatment. In this case, Natalie meets weekly with Mary Joan Stiuso, a nurse clinician, for individual psychotherapy and family sessions. Her mother attends a parenting group conducted by Nereida Lewin, M.A., a clinical psychologist.

"Ever since I've started seeing Ms. Stiuso, I've been communicating more with my mother, and understanding her better," Natalie says. "I never trusted my mother before, but the more I spoke to Ms. Stiuso, the more open I became with my mother."

"I used to be impatient with my mother's depression after she asked my father to leave us because he used drugs," continues Natalie. "Now I understand she did it for our good."

"I used to have a bad temper. I never controlled myself. Now teasing doesn't bother me. I count to 10. I've learned how to control myself. My grades have improved, too."

"No matter how many problems I have, I would never swallow pills again. It's not worth it." ■

### Learning New Ways to Solve Problems

Those who can be seen as outpatients enter the Clinic program immediately. The multidisciplinary treatment involves psychotherapy, family therapy, medication (if indicated), and possibly treatment of parents' psychiatric disorders.

An important goal of the program is teaching teenagers new ways of solving problems. "We show the kids that they're not helpless in their family situations. They learn to see options other than their impulsive, suicidal behavior."

Teenagers who find it difficult to discuss their problems may attend a writing workshop. Co-sponsored by New York State Poets in Public Service, this workshop utilizes patients' own poetry to assist them in expressing their feelings.

In 1985, Dr. Chambers and his staff counseled 150 teenagers who had attempted suicide. Unfortunately, many simply do not return after their assessment for outpatient treatment, notes Dr. Trautman.

In a study funded by the New York State Department of Mental Health, he is conducting home visits with those who do and do not return to determine what influences a family's decision to return. "Problems within the family and overall attitudes and past experiences with hospitals and physicians seem to make a difference," he says. ■



# ENTERING THE LABYRINTH OF CATASTROPHIC ILLNESS

For someone who has been stricken

by a catastrophic illness or injury—

any long-term, disabling affliction—

there is little peace of mind.

"Whether it is caused by AIDS, a rare disease, a virulent form of cancer, a serious accident, or an illness associated with aging, catastrophic illness affects absolutely every facet of the patient's life," says Esther Chachkes. "And that is true for everyone—rich, poor, young, old—absolutely everyone."

Catastrophic illness can hit at any age. There is, of course, a special sadness when a young person is stricken, and AIDS is killing many people in the prime of their lives. Yet, the tragedy is no less poignant for a young mother or a middle-aged couple who were looking forward to their retirement years. And while it may be easier to accept the illness of an elderly person who has lived a long, productive life, it is important to remember, notes Mary Ann Code, M.S.W., Social Work Supervisor, that the impact of long-term illness reaches far beyond the individual who suffers, to families and friends.

## **Different Lives; Shared Problems**

Every long-term patient is unique, but as the situations of Mrs. Reyes, Mrs. Hettinger, Ms. Ripley and Mr. Anderson demonstrate, many share the effects of a serious illness: loss of independence and control over one's life; loss of job and the identity and feelings of accomplishment a worklife provides; financial hardship; changes in family relationships; difficulty in maintaining friendships; and difficulty in maintaining a sense of self-worth.

For many, waiting to leave a hospital bed and move to the next phase of recovery, whether that means a nursing home, rehabilitation center, or home with attendants, can be the most trying ordeal.

"When I came into the Hospital, I didn't know it would be so hard to leave," Adolphia Reyes said. The petite, 32-year-old woman looked especially





small in the large, white-sheeted hospital bed, with fluffy cotton pads supporting her elbows, knees, and feet.

She lay there, unable to move without assistance, because of scleroderma, a degenerative disease. She had been diagnosed with the disease nine years earlier, but her symptoms had become acute only in the last few years.

Scleroderma is a rheumatic disease, explains Richard Rosenberg, M.D., the physician who treated Mrs. Reyes. "It affects the skin, gastrointestinal tract and especially the esophagus, the lungs, heart and kidney, and causes severe hypertension which further damages the organs."

Mrs. Reyes's lungs were damaged because of the disease, so that she was unable to take a deep breath. "It feels like breathing with a tight jacket on," Dr. Rosenberg says. There is no treatment for the disease, although the hypertension and other symptoms, such as gastrointestinal distress, can be treated, he adds. If the organs are affected, the prognosis for survival is poor: "Less than 50 percent over seven years," he says.

Mrs. Reyes had a difficult life, even apart from her disease. Her 12-year-old son has sickle-cell anemia, and her husband was killed in a car accident two years ago. But she kept her optimistic outlook, no matter what.

### **Facing a Fatal Illness**

"When I was first diagnosed, I became pregnant right away, even though the doctor said that I would have a high-risk birth," she said. "I knew my illness was fatal, and I didn't want to leave my little boy alone. Now I'm glad because my little girl is wonderful, and the two children are good companions."

When she was admitted in December 1986, Mrs. Reyes had pneumonia and was put on a respirator in the intensive care unit. "I saw a lot of people dying there, and that scared me. I worked hard to live."

Excellent medical care and the compassion of the PH staff helped revive her optimism. One of her greatest frustrations was that, because of a tracheotomy, she couldn't speak understandably at first. Somehow, a staff nurse, Elizabeth Hudson, R.N., recognized this articulate woman and found a way to communicate with her. "Elizabeth read my lips," Mrs. Reyes said. "She would sit with me whenever she had a chance and I would talk to her."

A speech pathologist at the Hospital helped Mrs. Reyes learn how to speak

so that others could understand her. "She had to keep reminding me to slow down when I talked," Mrs. Reyes said with a smile.

After six weeks, Mrs. Reyes no longer needed the full resources of a hospital. But she did need a full-time certified home health care attendant. While they all waited for the aide to be assigned to Mrs. Reyes, Angela Lloyd, M.S.W., her social worker, organized several meetings with Mrs. Reyes, her physician, nurses and others assigned to work with her and her family.

"The main idea was to establish a common approach to the patient's care," Ms. Lloyd says, "but the meetings also conveyed to Mrs. Reyes that she could play an active role as a member of her family and her health care team."

As the waiting stretched into weeks and then months, Ms. Lloyd arranged liberal visiting hours for the children. When the boy was admitted to the Hospital for problems relating to his sickle-cell anemia, Ms. Lloyd stayed in touch with his physician, nurses, and social worker and kept Mrs. Reyes current on her son's progress.

Even with her children visiting her once a week and her mother bringing household papers and bills so that she still had some control over her everyday life, Mrs. Reyes still longed to be home. "My children kept asking when I'd be coming home, and I wondered everyday, too." Finally, two home health aides who would each work a 12-hour shift became available, and she was able to go home.

The story does not have a happy ending: Mrs. Reyes developed pneumonia a week after leaving Presbyterian, and she died a week later. What remains is her spirit; she never had any delusions about the nature of her disease or its prognosis, and she lived each day as fully as possible.

"I never take anything for granted," she said, "and I appreciate everything I have."

### **Holding Tenaciously to Independence**

At age 87, Margaret Hettinger (not her real name) was an active member of her senior citizens' center, where she ate lunch nearly every day and participated in many activities.

Her outgoing nature helped save her life, as a matter of fact. When she failed to arrive at the center one day, the staff became concerned and telephoned the superintendent of her building. He



found her unconscious in her apartment, and arranged for an ambulance to bring her to PH.

"Mrs. Hettinger suffered a stroke," Rebecca Murphy, M.S.W., Assistant Director of Social Work Services at Presbyterian, says. "She received the medical care and rehabilitation services she needed and recovered well, but it was clear that she would not be able to take care of herself or conduct her daily activities as she'd been doing."

The widow stubbornly insisted on staying in her own neighborhood and in her own apartment. A home health aide was the most viable alternative for her.

"But she didn't want someone to wait on her," Ms. Murphy says, "and she worried about having a stranger in her home who would put the dishes in the

wrong places and disturb the routines of her life. We had to counsel her to accept the aide."

### **Treasure Hunting for Documents**

The next hurdle was finding a way to pay for the home aide. Medicaid was the best option, and PH social workers convinced her that the program was a form of insurance, rather than charity.

Collecting the multitude of forms necessary to complete the Medicaid application proved the greatest hardship. Mrs. Hettinger couldn't go home by herself, and no one else could begin to guess at her secret places for documents.

Her daughter came in from Chicago, and the treasure hunt was on. Bit by bit, the necessary papers were compiled and the application was completed by Margaret Ablon, Director of the Hos-



pital Care Unit, and her staff. Getting the application approved took another six weeks, but fortunately Mrs. Hettinger was able to go home without waiting.

Now, she's moving a bit more slowly than before the stroke as she approaches her 88th birthday, but she's back to her regular senior center activities and lunches once again.

### **Finding a Place for AIDS Patients**

Sandra Ripley (not her real name) was diagnosed with AIDS at a New York City hospital in December, and when she was released, she found herself on the street.

"I'd been living in a women's residence and they learned about my AIDS," she says. "I was released from the first hospital on Thursday, and on Friday they just put me out. I was devastated—I felt isolated and like I was nothing at all, and what did anything matter because I was going to die anyway. I stopped taking my medications and I was two steps from being a bag lady. I stopped caring about me."

Ms. Ripley knew the street well. The former drug abuser had dropped out of school and left home when she was 16. She had been jailed for drug-related offenses, and finally worked to free herself of cocaine and heroin habits.

She came into the PH emergency room in April, suffering from tuberculosis and AIDS. She had no friends and had not seen her family in many years. Catherine Paykin, M.S.W., the social worker assigned to her floor, encouraged Ms. Ripley to contact her family.

"It broke my heart," Ms. Ripley says. "My father came to visit me from Florida, and my sisters have been here several times. I didn't want to bring drugs around them and I didn't think they'd want to bother with me. You know, they don't use drugs and I always thought of them as squares—and squares don't get AIDS." Now she's thankful for their regular visits and their support.

After two months, Ms. Ripley was ready to be discharged, but finding a place for her was not so simple. "There are very few facilities for AIDS patients," Ms. Paykin says. "Crisis Intervention Services, a city agency, finds beds in city hotels and Y's for people who are physically independent, but these are far from ideal because there are no on-site services. And once a person has been diagnosed with AIDS, he or she cannot be released to a city shelter for the homeless."

One relatively new facility specifically

for AIDS patients is Bailey House. The 44-bed residence in Greenwich Village provides a drug-free environment and has medical and social work personnel on staff. Ms. Paykin arranged an interview between Ms. Ripley and a Bailey House social worker and accompanied her when the time came for the visit.

"We went there and I could see that it is a beautiful place," Ms. Ripley says, "and they said I was an ideal person for them. What's wonderful is that no one can discriminate against you, because everyone has the same disease."

Ms. Paykin has kept in touch with Ms. Ripley and her social workers at Bailey House. "It was a very good move and it is working out well," she says, "although her disease is advancing and her prognosis is not very good."

### **Waiting for the Nightmare to End**

It has been a long time since Jim Anderson (not his real name) felt well. His problems started when he was on assignment in the Korean War, when his feet and legs began breaking out in painful lesions. In later years, blood infections would accompany the disease for which he still has no firm diagnosis.

Whatever the problem was, the Veterans' Administration insisted it wasn't duty related, and consequently, offered only 10 percent disability compensation while Jim lived with unpredictable bouts of nearly unbearable pain in his legs.

Despite his medical problems, Jim held a job he loved as a part-time machine shop teacher until December of 1986. Up to that point, he and his wife, Mary, were able to live modestly. Although they were in debt from uninsured medical bills, they were happy, and proud of their son and daughter, who were grown and living lives of their own.

### **Enduring a Crisis**

Two days before Christmas 1986, Jim was admitted to a small New Jersey hospital, complaining of unbearable pain.

This was a different pain than he had experienced before. "I knew, I just knew something was very wrong this time," Mary says. But the medical team assigned to Jim's case couldn't find anything new. The physicians suggested that Jim go home, armed with steroids and painkillers, and learn to live with his problems.

Jim, described by Mary as "a big, strong kind of man who doesn't easily give in," regressed to where he couldn't



BAILEY HOUSE

## PLANT LINES AGAINST

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hold back his screams. By April, the pain had coursed up his legs and had intensified in his hips. He couldn't sit or walk.

Mary, frightened and not sure where to turn next, called a doctor—a friend who lived in another town. Without hesitation, he referred her husband to The Presbyterian Hospital.

After a battery of tests, PH physicians confirmed Mary's fears: something indeed was very wrong with Jim Anderson. A severe infection had lodged in his hips.

The physicians found that the infection had gone too far; Jim's hip bones had to be removed to save his life. He now is awaiting a hip replacement operation.

Jim will live, but probably never will walk again. Because of the active nature of the job he held, he no longer can teach.

The Andersons currently live on Mary's \$137 weekly salary from her job at a bakery. They receive no public assistance. Although he has hospitalization insurance, Jim has no disability coverage through his work plan. Mary isn't sure how they will eat when Jim is released from the Hospital. She waits for what she calls "a nightmare—a damned nightmare" to end.

### Stepping In

When Jim Anderson was admitted to Presbyterian, the staff recognized a need for help beyond medical treatment. Jim's physician called social worker Sara Fishman, who listened to Mary Anderson's rare, unfortunate story of how a couple can slip from the relative comforts of the middle class to the helplessness of the working poor.

Ms. Fishman discovered that Mary was driving four hours every day, five days a week, to be with her husband, leaving after work and returning home late at night. The commute alone left her exhausted and accounted for most of the money she earned. Mary didn't know where the money for her utility bills would come from, and for weeks she had subsisted on leftover bread from the bakery. She didn't even have enough money to replace her lost reading glasses.

"This is a situation where illness caused a major breakdown in a couple's life," Ms. Fishman says. "It's a case of the system not being able to meet their needs. They're too young for Medicare, and ineligible for Medicaid, disability insurance, food stamps, and similar services. So we've got to find something for them—help them explore resources

and give them support in whatever way possible."

Ms. Fishman helped Mary set priorities and learn to balance heavy responsibilities so that she feels less overwhelmed. In addition, she worked with Sandra Walsh, a Patient Representative, to arrange several services, such as free meals when Mary visits her husband. She parks without charge in the Hospital garage, and her transportation and some other expenses—such as eye-glasses—now are covered through a Social Work Services fund.

Meanwhile, Ms. Fishman has investigated Jim's Social Security status. Because Jim now is permanently disabled, he is entitled to benefits. However, it will be several months before his request is processed and payments begin.

"Some people hear about a case such as this and ask why the people aren't on welfare," Ms. Fishman explains. "Welfare is just not an alternative. Mary's salary, even though it doesn't begin to cover the Andersons' expenses, still is too much to qualify for Medicaid where the Andersons live."

Meanwhile, after consulting with the Andersons, Ms. Fishman has made calls to Jim's school administrator, with hopes of establishing a community fund for the Andersons to help them until they receive Social Security benefits. At the time this article was written, she was waiting for a response.

### Emphasizing Individual Strengths

"Despite all the problems in this crisis, there are strengths," Ms. Fishman says. "Strengths that keep these two together where other couples would have given up. Right now, we need to encourage those strong points and offer emotional support.

"It's amazing this woman hasn't given in," she continues. "Often, illness can destroy a family—a wife may begin to resent her sick husband, or somehow there's blame and hard feelings.

"In the Anderson's case, there is a strong bond between them and it is a solid family unit—Mary genuinely likes her husband. She loves him. That, I guess, is what makes the difference here."

It is impossible to put a happy face on catastrophic illness. Yet, many people at The Presbyterian Hospital—physicians, nurses, social workers, patient relations staff, and others—do as much as possible to enable all patients facing severe illness to retain their integrity, dignity, and a measure of control over their lives. ■



The Mayor gives the "thumbs up," sign to reporters, who wanted to know how he was doing.

### How'm I Doin'?

New York City Mayor Edward I. Koch was an honored patient at Presbyterian Hospital's Neurological Institute for a weekend in August, after suffering what physicians described as a "tiny, trivial" stroke.

The Mayor was referred to Presbyterian after suffering stroke symptoms that included dizziness, slurred speech, and a slight drooping of the left side of his face. PH has one of the largest stroke centers in the world, and also has the most advanced equipment, including a Magnetic Resonance Imaging (MRI) scanner, which can detect the slightest damage both to major arteries and small vessels.

J.P. Mohr, M.D., Director of the Stroke Center, and Sadek Hilal, M.D., Director of Neuroradiology, directed the Mayor's care during his brief stay at the Hospital.

In addition to the MRI scan, the Mayor benefited from the Hospital's Transcranial Doppler machine, similar to an ultrasound scanner, which permits physicians to "examine" major arteries in the brain through non-surgical techniques.

The tests showed that the major arteries in the Mayor's brain were clear, according to Dr. Hilal and Dr. Mohr, who said that he is not at risk for a major stroke. Robert Barrett, M.D., Associate Attending Neurologist at PH who was the Mayor's neurologist here, advised him to rest for three or four days after leaving PH.

By Sunday, Mayor Koch's speech was back to normal, as he proved by speaking briefly to reporters as he was leaving.

The Hospital was the center of attention from print and electronic media

from the entire metropolitan area and, indeed, the nation, throughout the Mayor's stay. "The attention paid to Mayor Koch's small cerebral incident last week," reported one item in *The New York Times*, "underscored a fact New Yorkers often forget: the 62-year-old Mayor is one of the two or three most powerful elected officials in America."

Thomas Q. Morris, M.D., President of The Presbyterian Hospital, thanked staff members for providing "exemplary care" for the Mayor and "all of our patients."



Members of the press listening to the Mayor and Dr. J.P. Mohr and Dr. Sadek Hilal, part of the team who directed the Mayor's care at PH. Dr. Hilal developed the MRI scanner that enabled PH physicians to detect a "tiny, trivial" stroke that was not visible on conventional CT scans.



## Rock and Roll Therapy

A crowd of youngsters in Alumni Auditorium rocked and rolled to the music of the lively band, *Nuvana*, in a special July celebration for parents and children associated with the Therapeutic Nursery and Family Center. Billy Soto, a friend of the Therapeutic Nursery, coordinated the program. Clowns and a magician also entertained the kids, thanks to

Hospital Audiences, a not-for-profit organization that arranges cultural events for hospitals in New York City.

Many of the participants in the Family Center and Therapeutic Nursery programs are abused children and their parents. "Isolation is closely associated with child abuse," says *Wendy Kamaiko*, Associate Director of the Nursery. "By celebrating holidays with our families, we can cut through some of that isolation."



## CAST Study

CPMC is one of 138 medical centers taking part in an international study, known as CAST, to determine whether treatment with

antiarrhythmic drugs will prevent sudden cardiac death. CAST (Cardiac Arrhythmia Suppression Trial), will involve some 5,000 patients in the United States, Canada, and Sweden who are to be enrolled in the



## Ribbon-Cutting at Babies Hospital

The Babies Hospital Division of PH showed off state-of-the-art operating and recovery rooms, office space, a therapeutic play area, and waiting rooms at a grand opening/ribbon-cutting in July that marked the

opening of Babies' fourth floor addition. After cutting the ribbon, Dr. Morris and his colleagues toured the facilities. Shown below from left: *R. Peter Altman, M.D.*, Director, Division of Pediatric Surgery; *Dr. Morris*; *Keith Reemtsma, M.D.*, Director of Surgery; and *Michael Katz, M.D.*, Director of Pediatrics.



study, funded in this country by the National Heart, Lung and Blood Institute. *J. Thomas Bigger, M.D.*, Attending Physician, Professor of Medicine, and chair of the steering committee for the new study,

said that the test is an important step in combatting a major killer. CAST is a follow-up to a pilot study (CAPS—Cardiac Arrhythmia Pilot Study), for which Dr. Bigger co-chaired the steering committee.

## Senior Center Staff Learn CPR Techniques

Socorro Rosado, PH Health Educator and Director of Health Promotion Programs at senior centers in Washington Heights/Inwood, can speak from experience about how important it is that people who work with seniors know basic lifesaving techniques. Not long ago, she and a retired nurse from PH were called into service to assist a heart attack victim at a local senior center.

That experience prompted

Ms. Rosado to arrange for the Hospital to provide instruction in cardio-pulmonary resuscitation to senior center staff throughout the community. Funds for the program, which began in April, were donated by the Presbyterian Hospital Auxiliary. Ms. Rosado conducts the sessions with *Frank Shipp*, a Supervisor in the Respiratory Care Department and a certified CPR instructor. "Our goal is to see that senior center staff members know the fundamentals of

lifesaving," Ms. Rosado says. "It's important not only for emergency situations, but also for the peace of mind of seniors who come to the centers."

In addition to CPR, Mr. Shipp teaches the Heimlich maneuver for choking victims and other basic lifesaving techniques. Together with Ms. Rosado, he also conducts demonstrations for seniors, explaining the signs of choking and heart failure and what measures bystanders can take until medical assistance arrives.



## Following A Dream

James Hatfield is an inspiration to young children who suffer from heart problems. After a childhood of suffering with heart disease, the 31-year-old Englishman took up sailing, and now sails around the world talking to young cardiac patients and raising funds for research and treatment of pediatric cardiology. In July, Mr. Hatfield sailed his 29-foot sloop, *British Heart III*, into New York and visited young heart patients at Babies Hospital, encouraging them to take care of themselves.

"In the end, the only person who really can take of you is you," Mr. Hatfield said. "Follow your dreams," he advised, "and remember, you can do anything you want to do." He promised to send postcards from England to the kids, and asked that they send some to him, too.



## Expressing Emotions Through Art



Presbyterian's Adult Hispanic Psychiatric Clinic was chosen by the New York Foundation for the Arts as sponsor of an "Artist-in-Residence Program" last spring, for the second consecutive year. Two artists, Josely Carvalho and Juan Boza, met biweekly with a group of patients and their families to teach drawing, painting and silk-screening techniques. "The Program has tremendous therapeutic value," says *Rafael Tavares, M.D.*, Clinic Director and Director of Community Psychiatry at PH.

"Last year, the program helped patients learn new tasks, confront their fears and problems, and reduce feelings of social isolation. It all leads to improved self-esteem for participants."

## Midlife Women's Center Opens

A new program specializing in health care for midlife and older women has opened at PH. The new facility will provide early detection of osteoporosis, nutrition and exercise information, and general education about physical and emotional changes that women in their 40's, 50's and 60's experience. *Patricia Hughes, M.D.*, Assistant Obstetrician/Gynecologist, is coordinator of the new program.



## CPMC CONSULTATION/ REFERRAL SERVICE

The Columbia-Presbyterian Consultation/Referral Service can help you find an appropriate CPMC physician. For information, call (212) 305-5156.

## IN MEMORIAM

*Lottie Morrison*, who served for many years as the Superintendent of Nursing at Sloane Hospital for Women of The Presbyterian Hospital, died recently in Sydney, Nova Scotia. She was 96 years old.

Ms. Morrison retired from Presbyterian in 1955 and moved to Sydney, where she was active in numerous organizations, including the Canadian Mental Health Association and the Canadian Cancer Society, of which she was an honorary vice president.

## NEUROLOGICAL SURGERY



*Emily Dane Friedman, M.D.*, Assistant Neurological Surgeon, has been awarded the 1987 Van Wagenen Fellowship from the American Association of Neurological Surgeons. This award is made to one neurosurgeon in the United States every

year who would benefit from scientific enrichment offered by European centers. The fellowship will sponsor her visits to three European laboratories investigating central nervous system transplantation. She also received the Charles A. Elsberg Fellowship in Neurological Surgery from the New York Academy of Medicine, and was appointed a Dana Fellow at P&S.

*Bennett M. Stein, M.D.*, Director of Service, attended the 10th Mexican Congress of Neurological Surgery in Mexico last summer. The conference was held to investigate new advances in the field of neurosurgery.

He also took part in the annual Stonwin Medical Conference. Clinicians and researchers from Japan, Yugoslavia, and the USSR took part in the meetings, which focused on surgery of the diencephalic region of the brain.

## NEUROLOGY

The Multiple Sclerosis Care Center gave a thank-you reception and plaque dedication to the Manhattan Society, a volunteer group of young professionals who are dedicated to the fight against MS. The group has fully underwritten the cost of maintaining the Care Center, which provides a wide range of comprehensive health care services to people who have MS or suspect they may have the disease. *Lewis Rowland, M.D.*, Director and Chairman of Neurology at PH and P&S, respectively, accepted the plaque from the Society.

CPMC is the only medical center in New York City participating in a nationwide study of early Parkinson's Disease patients to test the effects of two drugs in slowing the progress of the disease. *Stanley Fahn, M.D.*, Director of the Movement Disorders Center, is co-

principal investigator of the national trials, known as DATATOP (Deprenyl and Tocopherol Antioxidative Therapy of Parkinsonism).

*Charles R. Plank, M.D.*, Assistant Attending Neurologist, was invited to the Medical City and Medical College of Baghdad last summer, where he diagnosed patients and offered seminars to students.

## UROLOGY

Congratulations to *Mitchell C. Benson, M.D.*, Assistant Attending Urologist and Assistant Professor of Urology, on receiving the American Urological Association's second prize for clinical research. He delivered a lecture on "Tumor Cell Heterogeneity" at the AUA's annual meeting in California last spring. Dr. Benson also spoke at the National Cancer Institute consensus development conference on localized prostatic cancer.

## PRESBYTERIAN HOSPITAL AUXILIARY



*Dr. Morris* watches as *Christine Kister*, President of the Presbyterian Hospital Auxiliary, presents a check for \$50,000 on behalf of the Auxiliary to *Howard Clark*, Chairman of the Hospital Board. The funds will support a gift shop in the new Hospital building.

# COUNSELING CRIME VICTIMS

*The man said he was a plumber and he went through all the motions: he won her sympathy by claiming that a leak downstairs was caused by faulty pipes in her apartment, and when she asked for ID he presented a piece of paper that looked okay; then he checked out the pipes in the kitchen as if he knew what he was doing. It wasn't until she showed him the way to the bathroom that she realized her mistake, and by then it was too late.*

He pulled a knife and warned her that if she made a sound, he'd rape her six-year-old daughter who was asleep in the next room. The knife convinced her that he meant it. Then he raped her and fled.

"That was eight months ago," says Filomena Critelli, C.S.W., Director of Presbyterian's crime victims program, "and this woman still has nightmares. She is still so depressed that she has had to quit working as a hairdresser. She's lost weight and hasn't gotten over her feelings of distrust for others."

The reaction of Mrs. Cruz (not her real name) to the assault conforms to a pattern known as rape trauma syndrome. Other common reactions include shame and an inability to discuss what happened, pent-up rage that spills over into business and family interactions, self-blame, and a persistent feeling that the victim could have done something to prevent what happened. These feelings can last up to ten years, according to Ms. Critelli.

"Mrs. Cruz's family wants her to snap out of it," Ms. Critelli says. "They see the rape as 'only a little sex,' and can't understand why she can't deal with it. Part of that is that they can't face what happened, it makes them feel very bad, and even guilty.

"In fact," Ms. Critelli continues, "rape is one of the most insidious forms of violence there is. Sex is probably the most private thing we do, and all of a sudden it's in the context of a gun against your head or a knife against your throat. The rapist's gratification comes not from sex so much as the control and humiliation of another person."

A model program at Presbyterian, called VICTIMS (for Victims in Crisis:



Treatment in a Medical Setting), seeks to identify crime victims as soon as they come into the Hospital. Most are seen first in the emergency room, although referrals also come from the Ob/Gyn Service and other medical units.

The object of the program, which is funded by a grant from New York State, is to reduce the victim's trauma through immediate and follow-up counseling combined with referral to appropriate social service agencies. During daytime and evening hours, Ms. Critelli or another social worker is available in the ER, and in the evenings a social worker is on call. There also is a group of trained volunteers, many of them bilingual, who are on call to assist rape victims.

"Presbyterian is an ideal site for the model program, first because it already had a well-respected rape crisis program, which began in 1977," says Esther Chachkes. "It is also the only hospital in Washington Heights/Inwood, a diverse community with a mix of children, immigrants, and elderly—groups

that may be prey to criminals."

The program, which works with victims of all kinds of crimes, is unique because it is the only hospital-based victims program in the area. "Before, crime victims were seen in the ER for medical problems and sent home; no one looked at the trauma they experienced. Now we try to help victims cope with a terrible experience," Ms. Critelli says.

The grant enables Ms. Critelli to train Hospital personnel, including medical students, nurses, residents, and physicians, to identify and treat crime victims and refer them to the program.

The VICTIMS program also involves community education and outreach. Ms. Critelli speaks to area police and makes presentations to senior centers, Y's, and schools, and works with the District Attorney's office to address the special concerns and problems of crime victims. She also sits on a New York City task force against sexual assault, together with staff members from hospitals throughout the city.

While the program is available to all crime victims, rape is one of the crimes most frequently dealt with at the Hospital. The program also works closely with battered women and victims of assaults, especially the elderly, according to Ms. Critelli. "Fully 75 percent of the people we see are women," she says.

The program is effective in providing direct services, such as helping clients find new, safer housing or to obtain access to disability insurance or other medical benefits. Equally important is its mission to educate the public and government officials. But in the long run, counseling may have the greatest impact in helping victims put their lives back together.

"A crime like rape or assault can shake up a person's basic beliefs about life," Ms. Critelli says. "We grow up to believe that if we're good and treat people right, nothing bad will happen to us. When something does happen that is beyond our control, it is vital to talk it out and find ways to regain perspective. That's what we're trying to help people do through this program." ■





The Presbyterian Hospital  
Columbia-Presbyterian Medical Center  
New York, New York 10032-3784



# Stethoscope

*One Hundred Years of Caring for Children*



*at Babies Hospital*

*1887-1987*



# Stethoscope

VOLUME XLII, NO. 4, 1987

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**B**abies Hospital opened in 1887 as the first in the nation to care for sick infants—which explains its name. Over the past century it has blossomed into a major pediatric institution with many roles. As a division of The Presbyterian Hospital and the clinical component of Columbia University's Department of Pediatrics, Babies Hospital cares for all patients from prematurely born infants to those about to begin their independent adult life. As a community hospital for the Washington Heights/Inwood neighborhood, it excels in offering primary and preventive care. As a tertiary hospital with many subspecialty divisions, it offers the most sophisticated care to patients from all parts of this country and from many foreign countries. As a university hospital, it is a forum for research and training. This combination of basic care, of complex, innovative therapies and of discovery and teaching has established Babies Hospital as one of the great children's hospitals in the world.

Michael Katz, M.D.  
 Director, Pediatric Service, Babies Hospital Division  
 of The Presbyterian Hospital  
 Reuben S. Carpentier Professor & Chairman,  
 Department of Pediatrics,  
 Columbia University College of Physicians & Surgeons.





# THE CHILDREN OF BABIES HOSPITAL



A CENTURY AGO, THE IDEA OF a separate hospital for children was quite new. Yet, a small group of influential people in New York were convinced that the city needed a hospital to treat children, who suffered from many diseases that were killing them. They pulled together the resources that made Babies Hospital a reality.

Who are the children of Babies Hospital? They are premature infants with respiratory disorders who grow older with minimal residual problems, thanks to nasal prongs developed by a Presbyterian Hospital anesthesiologist and used in the Babies Neonatal Intensive Care Unit. They are children with congenital heart disease who are referred from throughout the world for treatment; in fact, Presbyterian is one of the few hospitals that offer heart transplantation for children. They are the 8-, 9-, and 10-year-olds who learn to control physical pain through self-hypnosis with the help of a PH developmental pediatrician.

They are members of families with a history of child abuse who have come to the Therapeutic Nursery or the Family Center, where their parents

learn how to prevent violent behavior. They are suburban children from Westchester, New Jersey or Long Island, who come here for cancer treatment. They are children from other countries who have been sent for consultation with a particular specialist. They are inner-city youths from local junior high schools who never have had a family doctor, let alone a specialist in adolescent medicine.

Although they cannot represent each of the thousands of children treated each year at Babies Hospital, Jimmy, Lisa and the Law family show why Babies Hospital is a magnet for all of these different children.

## **Changing Habits Now to Prevent Heart Disease Later**

Some might say that Jimmy (not a real name) has the cards stacked against him: his father had a heart attack at age 30, his paternal grandmother's heart attack occurred when she was in her forties and his maternal grandfather had a heart attack in his mid-thirties. At age two and a half, Jimmy himself has a cholesterol level of 300—nearly twice the acceptable levels of 170 or less.

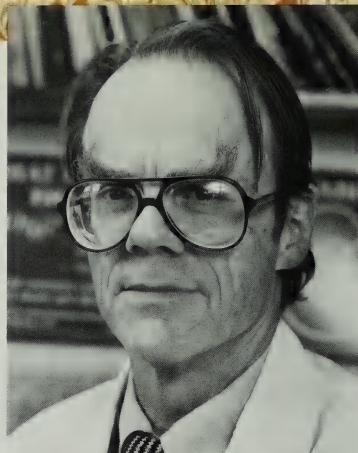
Fortunately, Jimmy's pediatrician on Long Island referred his family to the new Children's Cardiovascular Health Program at Presbyterian's Babies Hospital Division, which is tailor-made for at-risk children like Jimmy. Once Jimmy got to Babies Hospital, his cholesterol and lipid levels were recorded. Both "good," or high density lipoproteins, and "bad," or low density lipoproteins, were measured.

Then Jimmy was put on a diet, approved by the American Heart Association, so that gradually he lowered his consumption of fats and increased the amounts of complex carbohydrates he ate. Depending on his progress, he may be given medications as well. Both Richard Deckelbaum, M.D., and Welton Gersony, M.D., co-directors of the program, are cautious about prescribing medications for young children.

"These are long-term drug therapies. We want to see the effects of diet changes on Jimmy's cholesterol levels before deciding whether he'll require supplemental medications," says Dr. Deckelbaum, who is Associate Attending Pediatrician at PH and Associate Professor at P&S.







*Dr. Nicholas Cunningham, Director of Outpatient Pediatrics.*

"This is preventive medicine, and it will be years before we fully understand its effects," says Dr. Gersony, Attending Pediatrician and Professor of Pediatrics at P&S. "We're treating Jimmy now in the hopes that he won't have significant atherosclerosis or hypertension in another 30, 40 or 50 years. We can't change genetics, but we can change the environment to lessen the effects of unfortunate heredity."

Family history is one of the most important indicators that a child is likely to have heart disease in the future. "Even when a child's cholesterol levels and tests of other factors are normal, if heart disease runs in the family the child is at risk," Dr. Gersony says.

Dr. Deckelbaum and Dr. Gersony see the new program's purpose as twofold. "First, of course, it will benefit the individual children we see," Dr. Gersony says. "We intend to follow them through childhood and adolescence, evaluating them as completely as possible, and treating them with a combination of diet and, when indicated, drugs."

"In addition, this program will make a tremendous contribution to clinical research. By establishing cholesterol and blood lipid profiles and watching them over a period of years, we will be able to determine the effectiveness of this kind of treatment."

Even diet changes can be controversial, notes Dr. Deckelbaum. "People are worried that changing the diet of a young child may hamper growth. First, we won't tamper with the diets of children under age two. And second, studies have been done on children in Italy and Greece who

were brought up on a diet that resembles one approved by the American Heart Association who have thrived. But there is a lot to be learned yet. The program will allow us to study such questions."

Moderation is one key to the program's success. Children will always be tempted by ice cream and cake at a party. Exercise and nutrition will be emphasized as life changes rather than as a restrictive medical regimen, Dr. Gersony says.

"We don't want the child to feel that he's being punished because he can't share treats with other children," Dr. Deckelbaum says. "We're just asking that he stay with the diet most of the time."

As the children grow, the program will encourage them to follow what Dr. Gersony calls a prudent life style of no smoking, continued healthful diet and weight control and regular exercise.

In addition to Dr. Gersony and Dr. Deckelbaum, the program is staffed by nutritionist Beth Ellen Dobrin, nursing coordinator Linda O'Neill, R.N., M.A., a fellow, Peter Belamarich, M.D., and biomedical statisticians. Program staff work closely with Henry Ginsberg, M.D., Associate Attending Physician and Associate Professor of Medicine, and Associate Director of the Specialized Center for Research in Atherosclerosis (SCOR), which is federally funded to study these disorders in adults.

#### **When Thinness Counts Too Much**

Lisa (a composite of several girls in treatment at Babies Hospital) is a conscientious youngster who is seen by her teachers as a model student.

She attends an exclusive private school in Manhattan, and both her parents are professionals. During a routine physical examination, a school nurse spotted some problems in her body development, and referred her family to Joseph Silverman, M.D., Attending Pediatrician and Clinical Professor of Pediatrics at P&S. Her parents made an appointment right away.

Dr. Silverman, who has been with Babies since 1959, treats anorexia nervosa and bulimia. "These girls are preoccupied with body size, and they have a phobic avoidance of being fat. Most of them come from middle class or upper middle class families, and many of their families have a history of severe psychological problems." Dr. Silverman has treated some boys for anorexia, but most of his patients—some 95 percent—are girls and women.

Anorexia—which means lack of appetite and is a misnomer, Dr. Silverman notes—was described in Great Britain as early as the seventeenth century. Babies Hospital has been treating it for some 50 years, beginning with the work of the late Hilde Bruch, M.D.

Most teenagers are concerned about their body image, Dr. Silverman says, but the anorexic child takes this concern to an extreme. "We say that if a child is 'vulnerable,' and, for example, her brothers tease her about body shape, she may panic and starve herself, even if she's already actually underweight."

Lisa was admitted as an inpatient at Babies, and she and her parents entered psychotherapy. "We have found that individual psychotherapy



Mrs. Jennifer Law with her twins at the General Pediatric Group Practice (GPGP).

RENE PEREZ

is most effective in changing this behavior. We won't accept a girl for treatment unless both the child and the parents agree to undergo psychotherapy," Dr. Silverman says. He works closely with Stephen Bennett, M.D., Assistant Attending Psychiatrist at PH, to treat these patients.

Lisa has been an inpatient at Babies for two months and can expect to be here for another month or two. "We have superb nurses at Babies Hospital who are tremendously supportive," Dr. Silverman says. "And the in-hospital school allows these children to keep up with their school work." Once she goes home, Lisa will continue psychotherapy for at least two more years.

The young woman has a good chance of living a healthy, normal life. Although anorexia can be life-threatening if untreated, most of the patients at Babies go on to recover fully.

### Personal Care for Inner-City Families

Jennifer Law maneuvers the double stroller to the appointment desk in Vanderbilt Clinic, where she makes an appointment for her one-month-old twins, Keith and Kimberly. "A friend recommended that I come here to be delivered and it was the right decision. For the first time, my children have their own pediatrician. I appreciate that personal relationship and I feel more secure about my children's care."

Mrs. Law's twins are patients at the General Pediatric Group Practice, or GPGP. Staffed by pediatricians and nurse-practitioners, the GPGP was

one of the nation's first hospital-based pediatric group practices.

"Each practitioner sees his or her own patients by appointment," says Nicholas Cunningham, M.D., Dr. P.H., Director of the Outpatient Pediatrics Division at Presbyterian. "GPGP enables us to see Babies Hospital patients in a setting that is more like a doctor's private office than a clinic—even though it's physically part of the clinic."

Dr. Cunningham believes that the group practice model can be "contagious. Our goal is to provide integrated, one-class care to all of our patients. Continuous, complete, accessible care—that's the objective. And I think we've been eminently successful in achieving it."

Unfortunately, many neighborhood residents still tend to use the emergency room as the main source of primary medical care for their youngsters. This fall, another clinic, the "continuity care" clinic, implemented a pilot project to provide its patients with seven-day-a-week, 24-hour telephone coverage and a special telephone number for the clinic.

The continuity care clinics are staffed by Babies Hospital residents and attending pediatricians. One of their objectives in this program is to help parents distinguish true emergencies from more routine problems. Families enrolled in the continuity care clinic may call the special telephone number to reach their own pediatrician and nurse practitioner, who are familiar with their child. Between 5 p.m. and midnight and on weekends, the line is staffed by bilingual (English- and

Spanish-speaking) operators who can refer the call to either the child's doctor or an appropriate on-call physician. Operators will stay on the line to translate, if necessary.

The physician will speak with the parent, assess the problem and, if necessary, will request that the child come to the Hospital immediately or will make an appointment for a visit with the child's own physician during regular clinic hours.

"We want to educate parents about appropriate use of the emergency room, yet still encourage them to maintain a connection with the Hospital and bring their children for regular check-ups, vaccinations and other routine care," says Matilde Irigoyen, M.D., Director of the GPGP and continuity care clinic.

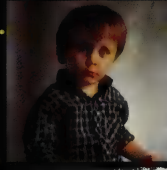
Many families are able to benefit from this kind of program, Dr. Cunningham notes. "But there still are those who are too disorganized to make and keep appointments and make sure that their children receive the proper medications or other treatments. We would rather have those parents use the emergency service in such situations than lose touch with them altogether."

Babies Hospital pediatricians promote the well-being of children like Jimmy, Lisa and the Law twins every day. They treat children with cystic fibrosis, cancer, juvenile diabetes, severe allergies and heart disease, so that all of these youngsters will have the best possible chance to live healthy, productive lives.

As Dr. Cunningham says, "Anything that promotes health care for children benefits both the individual child and the society in the long run." ■



*One Hundred*



*Years of Caring*



# THE HOSPITAL

THROUGH THE EYES  
OF A CHILD



JESSICA (NOT HER REAL NAME), age five, has been diagnosed with scoliosis, and her pediatrician has decided that she should have a corrective operation.

During the week before the operation, the youngster undergoes several medical procedures that help her become familiar with hospital equipment and staff. Her mother stayed with her during those procedures, and she was able to go home afterwards. But hospitalization is another story: what will happen to her in this big, strange place? The Child Life Program at Babies Hospital is designed to help Jessica and her family see the hospital experience from the child's point of view.

Like most young children, Jessica doesn't understand that she has to go through some pain if she is going to get better. And because she, like many children her age or younger, doesn't often verbalize her fears and feelings, it will be up to her parents and the Hospital staff to coax the monsters from the little girl's imagination.

### Being Hospitalized Is No Small Deal

"Any hospitalization is a major life event for a child," says Penelope Buschman, R.N., who counsels many Babies Hospital patients and their parents about their hospital-related anxieties. "Families have to be aware of how much their child can understand about what it means to be hospitalized. They also have to know their own biases toward illness and hospitals so they can understand why the child reacts the way he or she does."

Ms. Buschman cites the case of a five-year-old boy who was admitted for repair of an orthopedic anomaly. The boy's father was unpleasant, if not outright hostile, toward staff and quibbled about the necessity of the operation. Consequently, the child wasn't particularly sold on the idea either.

Stubborn as the father was, it took Ms. Buschman just one question to unlock the source of his antagonism. She asked him what his own hospital experiences had been.

The father, Ms. Buschman learned, had lived with the same disfiguring problem until he was a teenager. Although his corrective surgery was successful, the emotional scars never disappeared. To compound matters, his hospital stay had been a bad one.

The father didn't want the same for his son, and didn't want to admit to himself that his son had experienced the pain of having a congenital abnormality. Hospitalization of a child often brings parents to confront the guilt they may feel about their children's imperfections.

"But after he began to understand his own feelings," Ms. Buschman says, "he was able to get on with helping his son. As a result, the hospital experience became a good one for both of them."

### Parents As Healers

In the past, the brief, infrequent visiting hours in children's hospitals only contributed to the disruption to normal parent-child interaction. Today that same interaction is viewed as paramount in Babies Hospital's



approach to making children well.

"Parents know their own children better than any nurse or physician does," says Ms. Buschman. "They can tell us what the child's interests and fears are, and the pet names the child has for body parts and functions."

Moreover, Ms. Buschman says, when parents provide everyday care for a child, they bring some comforting familiarity into the child's hospital routine. "As much as possible," Ms. Buschman says, "we encourage parents to help their children at mealtime, to bathe them, dress them, and above all, play with them."

Unfortunately, Ms. Buschman concedes, not all parents, despite encouragement from hospital staff, are active in caring for their hospitalized children. When a child is chronically, seriously ill, the hospital stay may be the only time an exhausted parent can rest. Some parents avoid the hospital for fear of coming to terms with their children's illness and perhaps their undue sense of failure as parents.

### **Putting the Child in Control**

From a psychological viewpoint, a child is more likely to emerge from a

hospital stay with the sense of "I did it" if he or she feels some control, no matter how little, over the process.

Acting out a hospital experience gives a young patient the chance to make decisions and to re-enact a situation until it feels comfortable. By playing with children, Child Life specialists can help them work out some of the tougher parts of a hospital stay.

"If you never take the time to explain to a child why he's getting a shot, for example, he might make up his own reason for it. He might think, for example, that he's getting a shot because he was bad last week," says Judy Bushelow, a Child Life specialist at Babies Hospital. "Children may associate pain with punishment. So one of the things we do in the Child Life Program is talk to the children. Let them know they get shots because they need medicine—not because they are being punished for something."

On Monday afternoons an hour is set aside for organized medical play, a time when children can take control of some of their fears and learn why it sometimes has to hurt before they feel better. Part of the game here is honesty. "Shots and IVs hurt. We don't tell children they don't," says

Ms. Bushelow. "We tell them it's all right to yell a little bit and that it's okay to cry, too."

So when Miguel (or Dr. Miguel, as he is titled this afternoon) is handed the empty syringe without a needle, he wipes the doll's arm with alcohol, just like the nurse does when he gets a shot or a new IV line. He poses the syringe next to the doll. "Now, what does it feel like?" Judy asks the group around the table.

"Owwweeee!" shout the kids in unison. Dr. Miguel completes the injection and applies a bandage, which tells his patient that the procedure is completed. Bandages are very important to children, Judy explains. They mean that the child has made it through a difficult procedure.

### **More Than Playing**

The Child Life team works with parents, physicians and nursing staff at Babies Hospital to assess each child's needs. If a patient is well enough, he or she can come to one of the three playrooms on Babies 10. The rooms accommodate wheelchairs, cribs and beds, and ample space is allowed between tables so that children with IV poles, for instance,



can play or work on craft projects. Teenagers have their own lounge, complete with a big-screen television.

Children also can attend school at Babies Hospital. Three public school teachers provide instruction each weekday morning during the school year, covering kindergarten through twelfth grade. In the afternoons, children can arrange for individual tutoring. Children are not allowed to trade school for play in the mornings, however.

### Previewing the Scariest Part of the Hospital

A group of children look half-scared, half-eager as they watch the tour leader show them lights, beds, microscopes and other special equipment in the operating and recovery rooms. The tours, which began in 1987, take children on a step-by-step journey through the operating suite.

In non-threatening terms, Child Life staff explain what the anesthesia machine does, what an IV is and how the big light over the operating table works. They show children the nurses' station and demonstrate how wheelchairs work. "We may show them a stretcher, so they know it's

not something that really stretches you," says Sharon Herder, a Child Life specialist.

"Yeah, I know the machine puts me to sleep," says a seven-year-old boy. "But what if I wake up during the operation?"

"Eecccw!" The other children giggle and squirm when he asks the question, yet they listen carefully to the answer, which is one of the most frequent explanations the Child Life staff find themselves giving. The woman explains to the little boy that, no, there's no chance of his waking up too soon because the anesthesiologist (she says that word slowly) keeps the machine on until the operation is completed. And no, she says, anticipating a more serious question, you won't fall asleep forever, either.

"The tour is a time when nothing scary is going to happen," Ms. Herder says. "It's their time to talk and play and ask questions."

Equally important, Ms. Herder says, is the sense of relief some parents get by attending a pre-op tour with their children. "It takes away some of the responsibility of explaining what is going to happen. A lot of parents have no prior hospital experience

aside from childbirth, and stumble when their children hit them with questions."

After the tour and a visit to a patient room, the children and parents watch a film about having an operation. Then the child can play doctor in the Child Life Center. "This gives the parents and staff a chance to view the hospital experience through the child's eyes," Ms. Herder says.

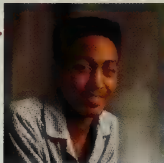
Of course, she adds, the presentation must be geared to the child's age and ability to understand. Three-year-olds, for instance, do not have the reasoning power to ask about waking up during surgery. Rather, they might just be curious about the masks the doctors wear and about the scary black anesthesia mask. Teenagers, as a rule, are concerned about scars and disfigurement. They may not always ask about them, but they too want to know, just as the younger patients, exactly what is going to happen to them.

The Child Life Program is a reminder that children differ from adults in many ways. It responds to the unique fears and curiosity—and playfulness—of young people facing the serious prospect of a spell in the hospital. ■



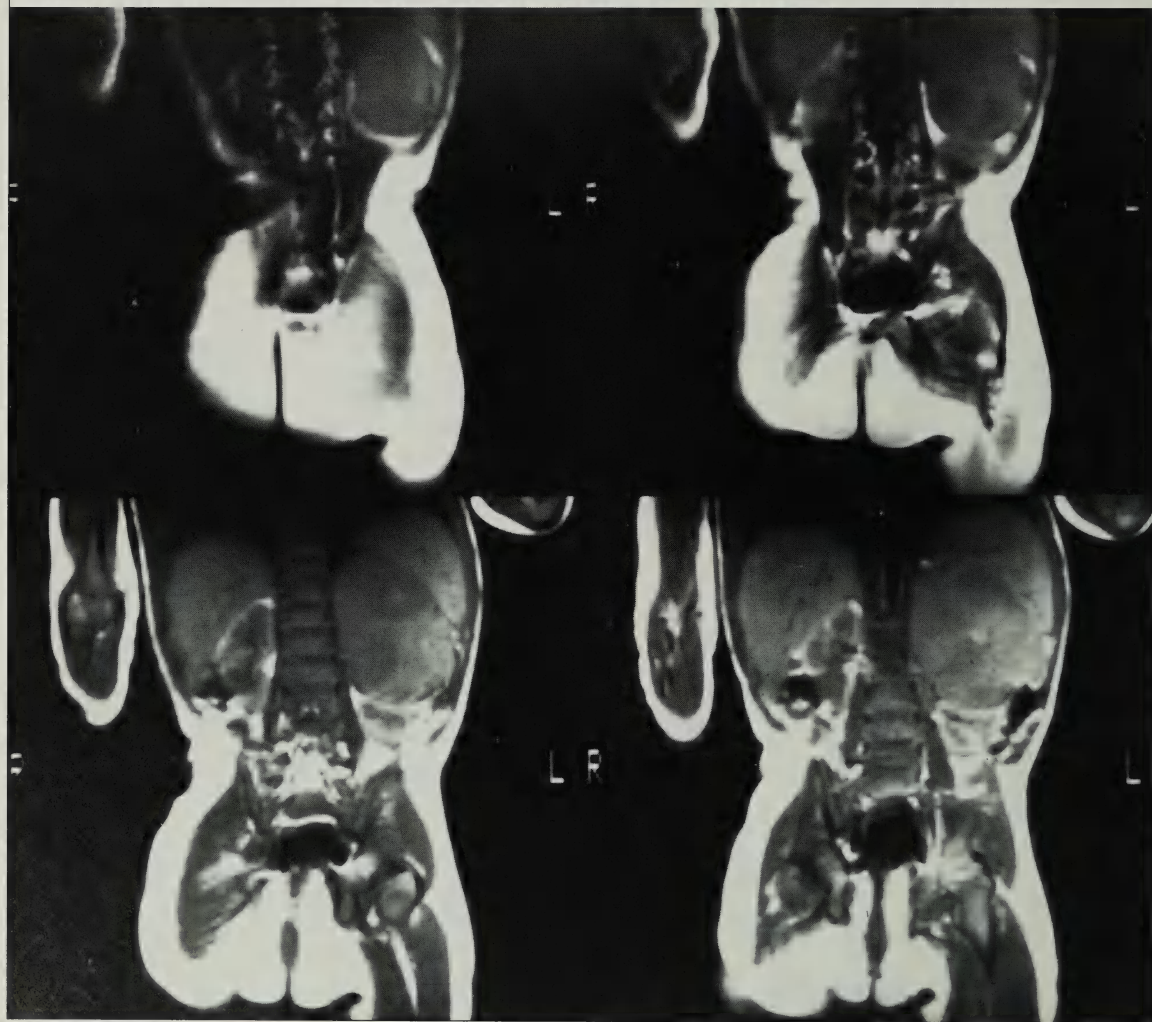


*One Hundred*



*Years of Caring*

# CHILDREN'S X-RAYS REALLY ARE DIFFERENT



IT HAS BEEN NEARLY 60 YEARS since a pediatrician at Babies Hospital asked the head of his department if he could open an X-ray department.

"At that time, X-raying children was widely discouraged," notes Walter E. Berdon, M.D., Director of Pediatric Radiology. "It was thought that X-raying would interfere with the clinical skills of pediatricians, who would rely too heavily on the films instead of a careful examination of the child.

"But it was decided to humor Dr. John P. Caffey by giving him an X-ray machine. Out of that small beginning developed the specialty of pediatric radiology. Today there are about 400 pediatric radiologists in the United States and the specialty exists throughout the world."

Dr. Caffey made many great contributions, Dr. Berdon says, and cited two in particular. First, while he studied the X-rays of children with diseases, he also contrasted them with X-rays of healthy children and characterized what is normal in children.

"Children's bones and organs are growing structures, which means that they have some different features than those of adults," Dr. Berdon says. "If you used adult standards to analyze children's X-rays, you would call a lot of things abnormal that really are normal. Diseases look different in children, and some diseases are seen only in children."

### Analyzing a Peculiar Pattern

Second, Dr. Caffey was the first physician to describe the battered child syndrome.

In reviewing films of children's fractures, Dr. Caffey noticed that a pattern ran through many of the injuries: sometimes peculiar changes in a bone appeared, or small pieces were chipped off a bone.

"We know now that this kind of injury is unique in trauma of young children," Dr. Berdon explains. Using X-rays, pediatric radiologists can tell when an injury occurred, and they can often find other, older injuries that further indicate child abuse. Pediatric radiology continues to play an important role in the diagnosis of child abuse.

Dr. Caffey went on to write the "bible" of pediatric radiology, "Pediatric X-Ray Diagnosis." His portrait in Dr. Berdon's office attests

to the influence his spirit continues to hold. "He taught people how to see children's X-rays," Dr. Berdon says. "That was probably his greatest contribution of all."

### New Technologies Bring Change

The Director and Chairman of Radiology at the Medical Center, David H. Baker, M.D., is a pediatric radiologist, and Dr. Caffey's successor. In addition, Babies Hospital has three full-time pediatric radiologists, Sarah Abramson, M.D., John B. Amodio, M.D., and Dr. Berdon. They are involved in such subspecialties as ultrasonography, CT scanning and magnetic resonance imaging.

The radiologists also work closely with many other pediatric specialists. "In addition to our regular daily conference with the house staff to review patients in the hospital, we also meet weekly with physicians in gastroenterology, surgery, urology, hema-



Christopher Coglianese returns to Babies Hospital for a post-operative examination.

tology/oncology, and orthopedic surgery," Dr. Berdon says.

Ultrasound, CT scanning and magnetic resonance imaging are bringing rapid changes to the field: every year an increasing percentage of all scans at Babies Hospital is done with one of the new technologies. In fact, many pediatric radiologists now call themselves "imagers," because traditional radiology represents only a fraction of their work in the 1980s.

Whether they are called radiologists or imagers, these specialists play a critical role in detecting children's diseases. "Just to give one example, we've made tremendous advances in the early detection of urinary tract diseases," Dr. Berdon says. "This means that we can prevent irreversible renal damage in children."

Radiologists also have done extensive work in helping pediatricians to diagnose problems that affect children's airways.

For children, the new technologies mean fewer invasive procedures. "We can look at a child's kidneys without having to inject contrast materials—in other words, without having to stick a needle into the arm. From the child's point of view, that's a great bonus," Dr. Berdon says.

One young man who can vouch for the benefits of the new technologies is 17-year-old Christopher Coglianese, who was suffering from a severe mid-back pain. He was diagnosed with scoliosis, but the intense pain was a mystery. "It felt like I had a hot piece of steel jammed into my back for ten months," Christopher says. The teenager is an active athlete and top student who wanted to continue pole-vaulting, his special interest, in college, but that goal was beginning to seem impossible. He was referred to Dr. David P. Roye, Jr., Assistant Orthopedic Surgeon at PH and Assistant Attending Professor of Orthopedic Surgery at P&S.

"His X-rays showed a deformity," says Dr. Roye. "We ran a bone scan, which showed a 'hot spot.' The image was diffuse, though, so we also used the magnetic resonance imager. We superimposed the scan onto the X-ray, which showed us precisely where we should do a scan with the magnetic resonance imager. The three images gave us something similar to a three-dimensional photograph, and sure enough, we found a tumor."

Dr. Roye performed the operation to excise the tumor, known as an osteoid osteoma, in December, and within two days Christopher was on his feet—and his intense pain was gone. Christopher's prognosis is excellent: Dr. Roye expects him to be pole-vaulting again by spring.

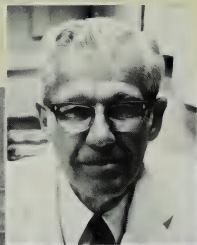
"The close interaction among services is vital, and that's what makes Babies Hospital a special place," Dr. Roye says. "Here you have the most sophisticated imaging techniques, and moreover, the clinician and the imaging specialist are in the same room at the same time. That's very different than sending in an X-ray and diagnosing an image long-distance."

Radiologists at Babies will continue to have a role in creating and using new imaging techniques to diagnose and treat children. ■



# Looking Back

## One Hundred Years of Caring



1887-1888

Babies Hospital incorporated; first BH building opens on New York's Upper East Side. A summer branch (which operated from 1888 to 1933) opens in Oceanic, New Jersey.

■ Two years earlier: Louis Pasteur develops vaccine for rabies.

1895

Babies Hospital is debt-free for the first time. Mortgage on original building is paid in full, thanks to contributions exceeding \$45,000, and the Hospital seeks larger quarters. A \$50,000 gift

from John D. Rockefeller enables the Hospital to secure a loan to build a new building.

■ First X-ray film developed by physicist Wilhelm Roentgen.

1902-1929

Babies Hospital moves into a new 8-story building on the Upper East Side. The facility, including eight wards of 68 beds, is equipped with heating and ventilation machinery, a disinfecting plant, diet kitchen, an

operating room, private wards, a morgue, a clinic room accommodating 40 students, a dormitory for 55 nurses and house staff, a solarium and a laboratory.

BH affiliates with Columbia University College of Physicians & Surgeons (1911).

1929-1933

BH opens the nation's first ward for premature infants, thus beginning a lasting commitment to neonatology.

■ World War I (1914-1918).

■ World-wide influenza epidemic (1918-1919).

■ Russian revolution (1917).

BH joins Columbia-Presbyterian Medical Center, and moves into a new 12-story building at 167th and Broadway at the CPMC campus.

# for Children at Babies Hospital

## 1887-1987



1949

■ **Economic depression** causes widespread unemployment throughout the world.

■ **Franklin D. Roosevelt** elected to first term as President of the United States.

BH opens a single 20-incubator nursery, consolidating several that were spread throughout Babies and the Sloane Hospital for Women.

■ **Following World War II**, antibiotics permit effective treatment of many infectious diseases.

1950-1953

Virginia Apgar, M.D., develops a simple method to test newborns' health that includes measurement of heart rate, respiratory effort, muscle tone, reflexes and irritability. The test continues to be used throughout the world.

■ **Dwight D. Eisenhower** elected President.

■ **Cold War** begins.

■ **Germany** divided.

■ **Korean** police action.

1960-1961

Dr. Rustin McIntosh retires after 28 years as Director of Pediatrics at BH. The "McIntosh era" set the standard of excellence that marks Babies Hospital today.

■ **By one run**, Roger Maris of the New York Yankees surpasses Babe Ruth's 34-year record of 60 homers in one season.

1974-1976

New 12-story BH building opens at 167th and Broadway.

■ **Richard M. Nixon** resigns from Presidency.

■ **Jimmy Carter** defeats Gerald Ford in presidential election.

1987

BH opens new, four-story addition, featuring advanced ORs, bright play areas for children, the latest imaging instruments.

■ **President Ronald Reagan** and Soviet leader Mikhail Gorbachev open talks to limit nuclear weapons in Europe.

For key to photos see page 23





# DEVELOPING A VACCINE FOR CHICKEN POX

WHEN BABIES HOSPITAL WAS founded 100 years ago, children were dying of such diseases as diphtheria, typhoid fever, scarlet fever, meningitis and many other infectious diseases. In the late 1800s, fewer than half of the infants in New York lived to become adults.

Physicians at Babies Hospital have been instrumental in combating infectious diseases. Perhaps most notable, Dr. Hattie Alexander, a pediatrician, developed the first serum therapy of bacterial meningitis in 1938. Dr. Michael Katz, Director and Chairman of Pediatrics at Presbyterian and P&S, is himself an expert in infectious diseases.

Routine vaccination has helped control such infectious diseases as mumps, measles, rubella, whooping cough and polio, so that they have become minor public health problems over the past 50 years. It's an astonishing list—with a perplexing omission. What about chicken pox?

## A Potential for Saving Lives

"I expect approval of a chicken pox vaccine within a year or two," says Anne Gershon, M.D., Attending Pediatrician, Professor of Pediatrics and Director of the Division of Infectious Diseases at Babies. Dr. Gershon

is leading a nationwide study of the vaccine for the National Institute of Allergy and Infectious Diseases, a branch of the National Institutes of Health. The vaccine is in the final stages of clinical evaluation, a decade and a half after it was first developed in Japan.

Dr. Gershon and her colleagues have found that chicken pox vaccine is safe and highly effective. Immunity is induced by injecting a live, attenuated (weakened) form of the virus into the body. "It's like giving a person a mild form of the infection," says Dr. Gershon. This stimulates the body to produce antibodies that protect against future infection.

The vaccine could prove invaluable, and even life saving, for people at high risk for severe chicken pox. Children with leukemia, for example, whose immune systems are weakened by radiotherapy and chemotherapy, would stand to benefit most.

"Often, children who could be cured of their leukemia die of chicken pox," says Dr. Gershon. The vaccine would also help adults who have not yet contracted the disease. For unknown reasons, those who escape the virus until adulthood end up with more serious cases.

The vaccine is proving to be safe,

with only occasional, minor side effects in the healthy children and adults who have been tested. Although some people don't receive full protection from the vaccine, they develop only a mild form of the disease after exposure to the virus.

## Considering the Risks of Routine Vaccination

Ultimately, the U.S. Food and Drug Administration will decide whether the chicken pox vaccine will be licensed in the United States and recommended as a routine vaccination for all children.

"Just about everybody would go along with licensing it for high risk groups," Dr. Gershon says. "The question is whether it should be licensed for healthy children and given as a routine vaccination. People are concerned about whether the immunity will be long-lasting. You don't want to immunize a child and have him or her lose the immunity as an adult. Personally, I think that's far-fetched, but it will take some time to find out."

Another concern is that the vaccine may increase the incidence of shingles, a painful inflammation of peripheral nerves near the skin that usually afflicts older adults. Shingles and

chicken pox are caused by the same virus, varicella zoster, a member of the herpes virus family. These viruses can become "latent" and lie dormant for years, and then resurface in a different form. Thus, anyone who gets chicken pox can develop shingles later in life. Researchers don't yet know whether people who are immunized get shingles more often than people who are exposed to the virus naturally. So far, that is not the case, Dr. Gershon reports, but no one has long-term experience with the vaccine.

Proponents of routine immunization might cite the case of a teenaged girl who came to Presbyterian with severe chicken pox. She had been taking corticosteroids for a neurological problem when she came into contact with the virus. Corticosteroids weaken the immune system, so what would have been a mild illness turned severe. At PH new antiviral agents were given to the young girl, but to no avail, and the girl died. "That would have been a preventable death had she been vaccinated at 15 months of age as a matter of routine," Dr. Gershon says.

"Chicken pox is not as bad a disease as measles, if you want to put it into perspective," she continues. "But I think it's worse than mumps, against which we do immunize. Plus, with chicken pox, there are secondary bacterial infections and a whole host of rare complications."

### Conquering Whooping Cough

Dr. Gershon and her colleagues also are evaluating an improved vaccine for whooping cough, or pertussis. Whooping cough, a respiratory disease characterized by an intensive cough, is now rare because of routine immunization in early infancy. Though the current vaccine is effective, public fears of vaccine-related illnesses threaten its usefulness.

Dr. Gershon believes these fears have been "vastly overplayed" in the media. "Clearly, whooping cough is much worse than any complications due to the vaccine." It is particularly severe in young infants, in whom the fatality rate is 50 percent. "We don't have a good therapy for the disease."

In an unprotected population, "the disease spreads very quickly and within a year or two can reach epidemic proportions," explains Dr. Gershon. This happened in Japan and England, where widespread fear of

side effects led to discontinuation of routine vaccination.

Serious central nervous system diseases, often referred to as toxic encephalopathies, have occurred in a small number of immunized children (about one out of every 100,000). However, no one has proved that the vaccine is to blame. "Many things can go wrong with babies between two and six months of age, which would happen anyway, whether or not they got pertussis vaccine," she emphasizes.

Nonetheless, the current vaccine could stand improvement. "It's effective only in about 85 percent of the recipients," explains Dr. Gershon, and it may cause such side effects as fever, local swelling, tenderness and soreness at the injection site.

Dr. Gershon and her colleagues are testing one of the newer "acellular"

whooping cough vaccines, which are made from antigens of the bacterium that causes the disease. The current vaccines are cruder preparations, simply consisting of killed bacterial cells. So far, it appears that acellular vaccines offer better protection against whooping cough and produce milder side effects.

"But people are predicting that, when large populations are immunized, we'll continue to see the encephalopathic syndromes," she says. "One way around that would be to immunize at, say, eight months of age (instead of at two months) to get beyond the normal high-risk period of infancy. But epidemiological calculations show that the incidence of pertussis in small babies will increase and be a greater problem than the rare encephalopathies." ■

## IDENTIFYING TWO INFECTIOUS DISEASES

### Chicken Pox

Chicken pox is caused by the varicella zoster virus, a member of the family of herpes viruses. Highly contagious, it typically affects children aged five through nine years, usually between January and May in the northern hemisphere. After an incubation period of 11 to 21 days, an infected child experiences a slight fever and tiredness. Then, a rash appears, beginning with small, red bumps. The bumps eventually become cloudy, fluid-filled blisters, capped with a reddish patch that ultimately breaks and forms a scab.

The disease ranges in severity, from a mild rash to several hundred bumps and a high fever. Most cases require no treatment. People with weakened immune systems (for example, cancer patients on chemotherapy) can be given antiviral agents, which reduce the symptoms but don't cure the disease. Fortunately, almost all children fully recover in one to two weeks. But serious complications can occur, including pneumonia and encephalitis, especially in adolescents and adults who contract the disease.

Children with chicken pox should not be given aspirin, because there is the possibility that it may cause Reye Syndrome, a serious and often fatal disease of the brain and liver. ■

### Whooping Cough

Whooping cough, or pertussis, results from a bacterial infection. Pertussis is Latin for "intensive cough," the most characteristic symptom of the disease.

Whooping cough commonly begins with a runny nose, mild cough and fever. In infants, severe upper respiratory problems can follow. After one to two weeks, the intensive coughing begins. This coughing is characterized by a series of five to ten coughs, which is followed by a sudden intake of air that produces an unmistakable "whooping" sound. Coughing can be quite severe, leading to exhaustion and weight loss and lasting about two to four weeks, and sometimes longer. As the child recovers, the coughing diminishes, though it may persist for several months.

Before the first whooping cough vaccines, very young children were the most common victims, many of whom died from complications (generally pneumonia). Today, because of widespread immunization during infancy, whooping cough is relatively rare. Even so, several thousand cases turn up in the U.S. each year, usually among improperly immunized or immunocompromised adolescents or young adults. Fortunately, whooping cough after one year of age is rarely fatal. ■



# One Hundred Years of Caring



Christina Fox with her children, Andrew and Beverly.

## WHEN A CHILD IS ILL, FAMILIES NEED HELP, TOO

**A** WOMAN TALKS through her tears. "It's so hard when she asks me why she can't do as much as the other kids. She knows she has an illness, but she still doesn't understand that she's not like everyone else."

"I know what you mean," says one of the other women in the informal support group. "I know how hard it is to tell mine that he has to take it easy."

These women are strangers, but the shared experience of having an acutely or chronically ill child has

brought them together. Group participants change from week to week, and the total time they spend together may be no more than 45 minutes to an hour, yet together they remind each other that they are not alone, and that having a sick child affects the entire family.

The group, which meets once a week, used to be called Heart to Heart, because it was created to provide support for parents of cardiac patients, explains Linda O'Neill, R.N., M.A., its co-leader. Now parents of children with other serious or chronic illnesses attend as well. Meetings are

held on Babies Hospital 8 South, for cardiac and other medical patients, and Ms. O'Neill and co-leader Marie Herrero, M.S.W., go from room to room every week to tell family members about the group. English- and Spanish-speaking parents are welcome.

"The parents find strength through one another," she says. "And we find that the meetings also help them vent their feelings. The parents are very candid about the care their children are receiving, and sometimes we can help if there's a particular problem."

Ms. O'Neill described a recent

meeting with the parents of a 14-year-old with Down syndrome who was facing open-heart surgery. "The mother didn't want to tell her son about the surgery, but the child was bright enough to know that something was wrong. The other parents convinced her that it was important for the child to know what was happening to him."

Parents also help each other to keep calm while their child is in the OR. There even may be a few light moments, when parents offer advice about neighborhood restaurants, as well as the more serious ones when parents help each other cope with leaving a child alone in the recovery room.

### "Is My Child the Only One?"

Andrew Fox was born with Hirschsprung Disease. This is a condition in which certain nerve elements are missing from the lower intestine, causing an obstruction, says John N. Schullinger, M.D., Associate Attending Surgeon at Presbyterian and Associate Clinical Professor of Surgery at P&S.

At two days of age, Andrew had a colostomy. "I'd just had a cesarean section, so I couldn't even be with him," says Christina Fox. "It was a very stressful time."

Andrew is now nine years old and generally healthy, after several more operations. "He has made steady progress toward normal bowel function since that first operation," Dr. Schullinger says.

Mrs. Fox, who teaches special education classes in Westchester, turned for support to other parents whose children were hospitalized. But once Andrew left Babies, that support system was gone, while all the stresses of having a sick infant remained. Moreover, helpful as it was to talk to the other parents, she longed to talk to parents of children with Hirschsprung disease.

That's when she began looking for other parents of children with the same or similar disease. That, in turn, gave her the idea for "Parents For Parents," the volunteer self-help group she created to help parents with sick children reach other parents in the same situation.

### A Family's Most Difficult Crisis

"Having a child who is seriously ill is the most serious crisis parents or a

family can face," Mrs. Fox says. "A child is your future, your responsibility, and when that child is in danger many families simply can't cope."

Sometimes a parent may find that he or she is all but living in the hospital for weeks on end. Only a strong support network and good communication can keep the parent from becoming isolated and estranged from a spouse, other children and friends and other relatives.

Often financial strains add to the family's anxieties. And a parent may turn to his or her own parents for emotional support, only to find that grandparents can't cope, either. "I knew there was a tremendous need for a group like Parents For Parents," Mrs. Fox says.

The most important service of Parents For Parents is the telephone referral network. Some 500 families are listed by the child's particular illness. Through the network, parents get to know others whose children have a similar illness. The group also publishes a newsletter and has monthly meetings at Babies Hospital and other area hospitals, mostly

attended by parents whose children are inpatients. "We have all ages, all illnesses, and we are developing a network with Spanish-speaking parents as well," Mrs. Fox says.

"Often, parents are on an emotional rollercoaster, where they're coping fine one day and falling apart the next. Parents For Parents puts them in touch with people who will listen sympathetically. The helping parents know the problems that come with a particular disease, and by relating their own experiences they can reassure newcomers, who may feel like they are going crazy."

Dr. Schullinger heads the 25-member professional advisory board of Parents For Parents. Board members include many pediatricians, nurses and social workers from The Presbyterian Hospital.

Parents For Parents is beginning to draw national attention. "People from all over the country write to us," Mrs. Fox says, "and we presented a paper on 'Models of Parent Support' at the professional meetings of the Association for the Care of Children's Health last year. Eventually we hope to have a nationwide network."■

## PARENTS AND CHILDREN RETURN TO CELEBRATE



Walking into the Neonatal Intensive Care Unit in Babies Hospital can be heart-wrenching: tiny babies, many weighing under two pounds, lie enclosed within plastic bubbles, amid tangles of lines, nasal prongs and flashing monitors.

Yet a visit of perhaps 15 minutes presents a view of hands-on high-tech care. Indeed, there is nothing impersonal about the care these infants receive, as a physician, nurse or visiting parent rearranges an IV tube, strokes a teeny knee or elbow, or picks a baby up to feed or hold.

A unique annual reunion proves that most of these parents have

reason to be optimistic. "We have parents who come back year after year to show off their children," says Paul Tonon, Administrator of the NICU, who helps the nursing and medical staff plan the reunion. "This year we had 250 people, and every year there are a few more. They come from throughout the metropolitan area and from as far away as south Jersey."

"In part, the parents come back to see the staff," says Mary Banfield, R.N., Nursing Care Clinician of the NICU. "We've weathered a crisis with them, and they want us to see how well their children are doing."

One of the highpoints of the day is a tour by the youngsters of the NICU. Most of them cannot believe they were ever that small or attached to all that stuff, Mr. Tonon says.

The rest of the day is spent enjoying refreshments, being entertained by Big Apple Circus clowns, and viewing a bulletin board with pictures of the children—some of them "then and now" shots.

"This is a very rewarding event for parents and staff," Ms. Banfield says. "And the children almost always learn something new about themselves."■



One Hundred



Years of Caring

# TREATING CHILDREN WITH

Mrs. Donna  
Carlyle with her  
son George.

# BRAIN TUMORS

A BRAIN TUMOR IS ONE OF the most devastating forms of cancer in children. If there is a positive side to the story, it is that only 1,500 to 2,000 new cases of such tumors in children are reported in the United States each year. But each of those cases represents an individual child fighting against tremendous odds.

The Presbyterian Hospital is the largest center for treatment of brain tumors in New York City, and one of the largest in the nation. In the 1960s and 70s, Chu H. Chang, M.D., Attending Radiation Oncologist, developed new radiotherapy techniques to attack brain tumors. He continues to make advances in this field.

Even with such intensive treatment and research, up to the late 1970s and even into the early 80s, the choices in treating brain tumors were extremely limited, says Darryl DeVivo, M.D., Attending Neurologist and Director of the Division of Pediatric Neurology at PH, and Sidney Carter Professor of Neurology at Columbia University College of Physicians & Surgeons. First the child would undergo surgery to remove as much of the tumor as

possible, followed by radiotherapy.

However, radiotherapy poses a great risk to the vulnerable developing nervous system. "Now we try to avoid using radiotherapy until the child is over two years of age," Dr. DeVivo says. "Unfortunately, the alternatives are limited, but there is new hope."

Treatment and prognosis depend ultimately on the kind of tumor the child has. The patterns of nervous system tumors—which include tumors of the spine—are very different in adults and children. "Some 60 percent of adult brain tumors fall into the category of glioblastoma," Dr. DeVivo says. "In children we see many different kinds of brain tumors."

The most common types of children's brain tumors are medulloblastomas, astrocytomas, ependymomas, and brainstem gliomas. Each has its own biological characteristics and response to treatment, and success with one does not mean success with any of the others, Dr. DeVivo notes.

Medulloblastomas often can be removed by surgery and usually are responsive to radiotherapy. Yet, Dr.

DeVivo says, these tumors frequently relapse.

Prognosis for these patients is relatively good: 40 to 50 percent of children with medulloblastomas will survive after five years and fewer than 30 percent after ten years. "That's better than is the case with many other pediatric brain tumors, but it is hardly ideal," Dr. DeVivo says. By contrast, in one of the worst cases, that of brainstem glioma, the five-year survival rate is about 18 percent.

## Chemotherapy Offers a New Treatment Option

By about 1970, advances in surgery and radiotherapy had improved the prognosis of children with brain tumors. Now the stage was set to add chemotherapy. Encouragement came from success with a different form of children's cancer—acute lymphocytic leukemia. Until about 1970, a child diagnosed with the disease essentially was handed a death sentence—it responded neither to surgery nor radiotherapy. But radiotherapy combined with new kinds of chemotherapy began to

prove effective in treating it.

"We went from a dismal situation to a promising one: now we can expect that a majority of children with acute lymphocytic leukemia can be effectively treated, and can expect to live long and productive lives," Dr. DeVivo says.

The success with leukemia actually illuminated problems and promising directions in using chemotherapy to treat brain tumors, says James H. Garvin, M.D., Assistant Attending Pediatrician at PH and Assistant Professor of Pediatrics at P&S, who directs the Oncology Section of Babies Hospital. Dr. Garvin is a member of a team headed by Sergio Piomelli, M.D., Director of the Division of Pediatric Hematology.

"Even following chemotherapy, leukemia cells still would be found in the spinal cord and nervous system," Dr. Garvin says. "It became apparent that that part of the body was not being reached by these drugs. This just highlighted the difficulty of getting drugs to penetrate the central nervous system, which is organized to keep out most chemical substances. Injecting medicines directly into the spinal fluid and giving radiotherapy to the brain and spinal cord cut the relapse rate dramatically."

The first children with brain tumors to receive chemotherapy were those whose tumors had recurred after surgery and radiotherapy—in other words, after all known treatment options had been used. The work was largely experimental and it helped physicians identify effective drugs and also the kinds of tumors that responded readily to chemotherapy.

### **Refining Chemotherapy Treatment**

Clinicians in hematology/oncology at Babies now are continually testing new drugs and drug combinations. They also are studying new treatments for patients with recurrent brain tumors. "Some are brand new," Dr. Garvin says, "and others are analogs of drugs already in use. We always hope that if we can lower the dosage of a drug, for example, we also will lessen its side effects."

The Presbyterian Hospital is part of the Children's Cancer Study Group, whose members include more than 20 major children's hospitals across the country. One problem in assessing meaningful clinical results is that the

incidence of brain tumors in children is small, and even the largest hospitals have a patient population of only 40 to 50 children. The Children's Cancer Study Group enables clinicians to test and assess treatments in a larger number of patients than is possible at a single medical center.

In 1977, the group undertook a study to assess treatment that combined chemotherapy and radiotherapy of astrocytomas, medulloblastomas and brainstem gliomas. This was a long-range study, because it took about three years to accumulate enough patients to be worthwhile, and another two to three years to complete the study and assess the results. Coincidentally, at the same time a similar study was being conducted in Europe.

The results are different for each of the three types of tumor. In the case of astrocytomas, chemotherapy showed a clear advantage, especially in the most malignant form of the disease. This study offered the first demonstration of the effectiveness of chemotherapy in treating this kind of tumor.

For medulloblastomas, chemotherapy showed some advantage, although less striking than for astrocytomas. But the test showed no improvement in the treatment of brainstem gliomas. "This is the most relentless form of brain tumor, with the lowest cure rate, and it is the most frustrating," Dr. Garvin says.

At Presbyterian, physicians try to enroll all children in such tests. "Usually families welcome the opportunity to be part of a test," Dr. Garvin says, adding, "Of course, if results clearly show that one treatment is superior to another, we will use the more effective treatment."

### **Genetics Opens New Possibilities**

In the late 1980s, treatment and research continue on all three fronts: surgery, radiotherapy, and chemotherapy. And exciting discoveries are being made by molecular geneticists.

"The geneticists hold the key to the future," Dr. DeVivo says. "They are beginning to identify the exact genes that determine various diseases. I believe that in the near future molecular geneticists will develop a test that will tell us whether a child has a gene for medulloblastoma, for example."

Dr. DeVivo and his colleagues have encouraged a multidisciplinary approach to treating and studying brain tumors. Most recently, a monthly pediatric neuro-oncology conference has been instituted, which includes pediatric neurology; hematology/oncology, with Drs. Piomelli and Garvin, and Ria Hawks, R.N.; neurosurgery, with Peter Carmel, M.D., Attending Neurological Surgeon and Professor of Clinical Neurological Surgery; radiation oncology, with Dr. Chang and Karen Fountain, M.D., Associate Attending Radiation Oncologist and Associate Clinical Professor of Radiation Oncology; and neuroradiology with Sadek Hilal, M.D., Attending Radiologist and Professor of Radiology, and Jacqueline Bello, M.D., Assistant Attending Radiologist and Assistant Professor of Radiology.

"The idea is to talk about categories of tumors and concepts related to diagnosis, treatment and direction of research, rather than to discuss individual patients. We already have a pediatric tumor board that meets to discuss the management of individual children's tumors. The pediatric neuro-oncology conference will let us talk about broader issues."

The Colleen Giblin Foundation, established by Paul and Vicki Giblin as a memorial to their daughter, whose death at age 4 was caused by a brain tumor, is contributing to this interdisciplinary study, in part through creation of the Giblin lectureship. The lectureship has allowed Dr. DeVivo to bring the most prominent researchers to CPMC to discuss their work. The lectureship is stimulating new approaches to treatment and research. The next lecture, scheduled for April 1988, will bring Professor Bengt Westermark from Upsalla, Sweden. He will discuss the biological behavior of cultured brain tumor tissue. The Giblins also have contributed to research projects at CPMC.

Dr. DeVivo and his colleagues are cautiously optimistic. "It's important to remember," Dr. Garvin says, "that in every case the progress is stepwise—in other words, we improve the cure rate by perhaps 10 to 15 percent every few years. But with brain tumors, we have a long way to go, so even a 10 to 15 percent improvement is significant." ■



# SETTING THE SECRET VOICE FREE

## *Inside My Shell*

Inside my shell is a place  
which is secluded  
with all my thoughts.  
Thoughts which can never be told  
because I'm so afraid  
of what people may say or think.  
Thoughts  
which I can never bear  
to let out of my mind.

Inside my shell there is no hurt,  
there is no pain.  
Inside my shell I have no fears.  
I am so afraid of the outside world,  
so afraid  
of getting laughed at and being hurt.  
I am a person  
who was put on earth  
but also I am somewhat like a clam  
trapped inside of a shell.

This world that people call their home  
is so fearful to me.

I don't know when  
or if the time will come  
that I will no longer have to face fear,  
that I will someday love  
and not get hurt.  
Until this time comes  
I must remain  
inside my shell  
until it's safe to come out  
or until someone lets loose  
what is locked up inside.

MARIA HAS TOO MANY secrets. They confuse her. Some of them quietly enrage her. Once she tried suicide because of them.

Until recently, 15-year-old Maria (not her real name) was withdrawn and friendless, steadfastly avoiding self-disclosure. Not even her psychiatrist could pry her emotional lid.

Yet, within Maria, like everyone, was the very strong need to be heard. A poet working with Presbyterian Hospital's Child Psychiatry Service helped her find a voice.

Once a week for 90 minutes or so, Maria now goes to a teen writing workshop in Babies Hospital. Seven

other girls, most of whom have tried suicide too, join her.

Sometimes she writes from class discussions. Other times she just sits and listens to poet-teacher Joan Halperin read a story. Maria might write about that story next week, or maybe she won't. Nobody there is going to judge her performance. She just writes because it feels good.

In Maria's case, one can't underestimate the importance of feeling good.

"Kids who don't like to talk have a hard time one-on-one with a therapist, explains child psychiatrist Dr. Paul Trautman. Dr. Trautman, Director of the Child and Adolescent

Depression and Suicidal Disorders Clinic in Pediatric Psychiatry, helped initiate the program two years ago in cooperation with Poets in Public Service, a non-profit organization that brings professional writers such as Joan Halperin into schools and community settings.

## **Belonging: A New Feeling**

Most of the group members are what Joan Halperin calls loners. "These are people who believe their feelings aren't good enough," she says. "They tend to be very passive and don't know how to express their anger."

But by exploring their emotions and learning to express them in strong, honest language, the youngsters strengthen their sense of identity. Slowly, they're able to share their deep-seated feelings. The sharing process fosters a closeness among the members, many of whom begin to socialize together outside class.

"If they stick with the program," Ms. Halperin says, "they develop an acceptance of their own feelings. Beyond that, they belong, often for the first time, to a peer group."

Ms. Halperin is careful about not calling the meetings therapy sessions. She'd much rather call the program a writers' club. "Although what we do here is therapeutic, their feeling is they're coming here for writing, which is true."

Like most writers' groups, the members are invited to read aloud. It usually takes one or two readers to get the rest of them going, Ms. Halperin says. And sometimes, if the material is of a particularly sensitive nature, they'll show it to her after class instead.

"I always have to reassure them that this isn't school, that I have no connection with their teachers and that they won't be graded," Ms. Halperin says. "I'd never try to put a grade on creativity, anyway."

At the end of the school year, the group selects its best works to be compiled in an anthology. The most recent publication, "Rainbow of Emotion," was presented at a party for poets, parents and staff in November.

Getting published is one of the program's perks, but Ms. Halperin doesn't like to advertise that as the end goal. "That in itself isn't productive," she says. "It's the thinking process, the self-discovery that is most important." ■

# FOR THE BENEFIT OF THE CHILDREN



## FROM THE DAY BABIES

Hospital opened its doors, many individuals have devoted time and provided financial aid to benefit the children treated there. Indeed, the Hospital was able to open in the first place because of the fund-raising efforts and generosity of the founders, who included Mrs. Andrew H. Smith, Mrs. Thomas E. Satterthwaite and Mrs. James Lenox Banks, who made up the first Board of Managers. This small but influential group convinced many of New York's most prominent citizens to join their cause and the earliest gifts, listed line by line in the first Babies Hospital Annual Report, dated 1890, ranged from three of \$1,000 (including one from Mrs. W. H. Vanderbilt), to many gifts of \$1.

That first report also mentions Cribside, Clothing, Reception and Nursing Committees. "It would be manifestly unjust, were we not to tell here of the several other groups of girls, who work in their own organizations, yet are enrolled among the Crib-sides as auxiliaries. In their busy city life, in their village homes, in the mountains, and beside the sea, busy fingers have worked for, and earnest hearts have remembered the Babies Hospital."

In the founders' spirit, the Board of Women Managers (the name was changed soon after the Hospital was founded) continues to be a source of financial support to Babies Hospital. Projects supported by them now include the Therapeutic Nursery for abused or neglected infants and children, and medical education programs.

Mrs. Anne Millard, President of the Board, has just announced a gift of \$100,000 in honor of the Babies Hospital Centennial, to initiate endowment of the Board of Women Managers Fellowship. When the endowment is completed, the funds

will support a fellow in training in a pediatric specialty. "We want to ensure the continuing excellence of Babies Hospital," Mrs. Millard says. "By creating this new fellowship, the Hospital will strengthen its leadership position in pediatric clinical care, education and research."

The Associates of Babies Hospital, co-chaired by Stephanie French and Rebecca Rozen, provide support for public education and other important programs. They have sponsored a number of "House Calls" by prominent Presbyterian Hospital physicians. For example, David Royce, M.D., Assistant Attending Orthopedic Surgeon, spoke on new advances in orthopedic surgery, and Michael Katz, M.D., Director and Chairman of Pediatrics at Babies Hospital, is scheduled to discuss infectious diseases that children might contract while traveling.

## A Fund with Heart

The Babies Heart Fund was founded by the parents of children who have been treated for cardiovascular defects and diseases at Babies Hospital. Their "Sunday Strolls Through SoHo," Heart Day raffle, and Heartbeat Cabaret are high-spirited events that provide full support for a fellowship in cardiology at Babies Hospital.

Not unusually, a heartwarming story is at the root of the Heartbeat Cabaret. Charlotte Poth underwent open heart surgery at Babies Hospital to correct a congenital heart defect at the age of seven months. "I was frightened for my child, yet I saw how this hospital gives the gift of life. I wanted to do something in return," says Charlotte's mother, Charity Sulcer Poth. She and her husband, Christopher, initiated the benefit as a way to say "thank you" for their daughter's care.

The Metropolitan Fund for Babies

Hospital raises money for treatment and research of childhood cancer. The group's first black tie dinner dance was held in December at the Harmonie Club. The party, chaired by Ellen Lazar, Nancy Brown and Richard Rous, raised more than \$35,000 to support the Children's Cancer Program at Babies.

Last spring, a group of New York high school students organized a disco dance to raise money for Babies Hospital. "We needed funding to continue the Big Apple Circus Clown Care Unit, the wonderful program involving clowns from the Big Apple Circus," says Virginia Keim, Director of Development for Babies Hospital, "and the teenagers responded to that need."

All of these individuals, in carrying on a tradition of supporting outstanding treatment for children, ensure that Babies Hospital will continue to be a leader in pediatrics as it enters its second century of caring for children. ■

## CELEBRATING 100 YEARS

The Presbyterian Hospital Trustees, Board of Women Managers and Babies Hospital Associates have planned a gala fund-raising dinner in February at the Waldorf-Astoria Hotel in honor of the Hospital's 100th birthday. The Centennial Celebration features Tommy Tune, one of Broadway's most talented dancers and choreographers, in a musical salute to Fred Astaire.

Co-chairing the event are Mr. and Mrs. Howard Clark (Mr. Clark is Chairman of the Board of The Presbyterian Hospital) and Mr. and Mrs. Charles D. Peebler, Jr. (Mr. Peebler is a Hospital Trustee). ■





## Hospital Trustees Elected

The Board of Trustees of The Presbyterian Hospital has announced the elections of *Thomas L. Chrystie* (left) and *Arthur F. Ryan* to the Board.

Thomas L. Chrystie, an investment banker, is Adviser on Strategy to Merrill Lynch & Co. He has spent his entire business career at Merrill Lynch, where he expanded its investment banking activities. He co-edited "Left-Hand Financing: An Emerging Field of Corporate Finance," technically rooted in specialty financing.



Mr. Chrystie was formerly a Trustee of Columbia University. He is director of several corporations, including Philips Industries and Signode Industries. He received a Bachelor of Arts Degree, with election to Phi Beta Kappa, from Columbia University, and a Master of Business Administration from New York University. Mr. Chrystie is a member of the Securities Industry Association, the New York Society of Security Analysts and the Down Town Association. He is married and has five children.

Arthur F. Ryan is Vice Chairman in charge of

Individual Banking of the Chase Manhattan Bank, N.A. His responsibilities include Chase's credit card operations and private banking businesses, Chase Home Mortgage Corporation, Personal Financial Services, Education Finance, the Metropolitan Community Bank, Chase Lincoln First and Chase Banks of Arizona, Florida, Maryland and Ohio. Mr. Ryan has been an executive at Chase since 1972.

Mr. Ryan is a Trustee of Pace University, First Vice President of the New York State Bankers Association and a member of the Business Advisory Council at the Carnegie Mellon Graduate School of Industrial Engineering.

A graduate of Providence College with a B.A. in mathematics, Mr. Ryan attended graduate school at American University while serving as a lieutenant in the U.S. Army.

Mr. Ryan is married and has four children. ■

## Focus: NY Dominican Community Health

A two-day conference on Hispanic Health Care Approaches in New York: A Focus on Dominicans, was held in October. The conference was sponsored by The Presbyterian Hospital, Columbia University School of Public Health and the Universidad Autonoma de Santo Domingo.

The sessions began with demographic information and a socio-cultural profile of Dominican patients seen at Presbyterian. Speakers included *Thomas Q. Morris, M.D.*, President of The Presbyterian Hospital; *Allan Rosenfield, M.D.*, Dean, Columbia University School of Public Health; *Dr. Ney Arias Lora*, Minister of Health, Dominican Republic; *Rafael Tavares, M.D.*, Assistant Attending Psychiatrist; and *Rafael A. Lantigua, M.D.*, Assistant Attending Physician. ■

## IN MEMORIAM



*Robert G. Bertsch, M.D.*, Director of Clinical Clerkships in Surgery at PH and Associate Clinical Professor of Surgery at P&S, died in September of a brain tumor at age 56. Dr. Bertsch joined the staff of PH in 1965. He retired in June.

He is survived by his wife and three daughters. A memorial service was held at the Hospital's Pauline A. Hartford Chapel in September.

*George E. Daniels, M.D.*, a Consultant in Psychiatry at Presbyterian and co-founder and former Director of the Columbia Psychoanalytic Center for Training and Research, died in August. He was 92 years old.

Dr. Daniels became an Associate in Psychiatry in 1929 and Assistant Professor of Clinical Psychiatry at P&S in 1930. He was named Attending Psychiatrist and Professor of Clinical Psychiatry in 1936, and Director of the Psychoanalytic Clinic in 1957, a position he held until his retirement in 1961. He retired in 1979.

Dr. Daniels is survived by his wife and two sons. A memorial service was held at PH in November.



*Carl R. Wise, M.D.*, retired Assistant Vice President for Professional Services to Patients at Presbyterian, died in October at age 79.

Dr. Wise, a native of Charleston, West Virginia, graduated from the University of West Virginia and received his M.D. degree from Harvard Medical School. He completed his internship and residency in medicine at The Presbyterian Hos-

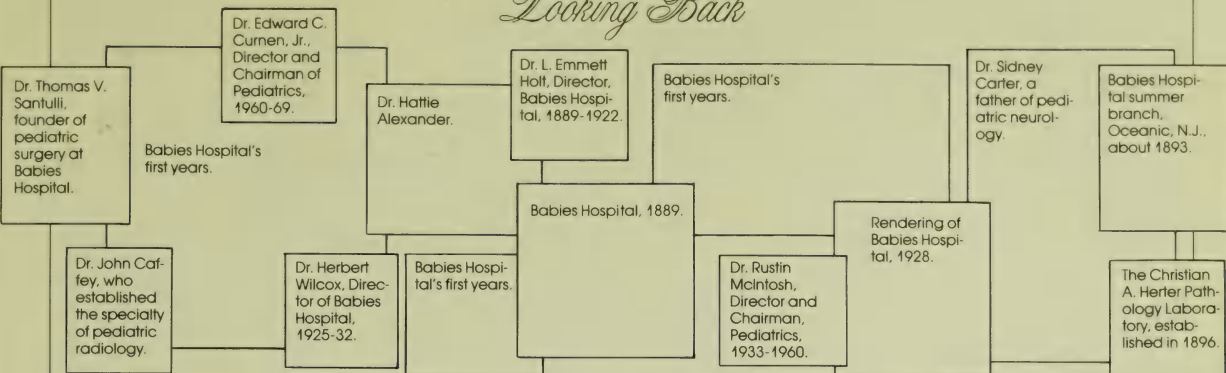
pital, and was appointed Assistant Physician and Assistant Professor of Medicine at P&S in 1937.

During World War II, Dr. Wise rose from captain to lieutenant colonel in the U.S. Army Medical Corps. After the war, Dr. Wise resumed his duties at Presbyterian and P&S. He was named Medical Officer at Columbia University in 1948, and Assistant Vice President for Professional Services to Patients at Presbyterian in 1961. He held that position until he retired in 1975.

Following his retirement from PH, he became director of the Westchester Health Maintenance Organization.

Dr. Wise is survived by his wife and three sons. ■

# Looking Back



Special thanks to photographer Elizabeth Wilcox.

## Alumni Society Dinner Mixes Past and Current Events

The first Thursday in November is the date of The Presbyterian Hospital Alumni Society's Annual Dinner, an evening when PH's who graduated from the residency programs here get together to catch up with their colleagues in

a relaxed setting.

This year, Calvin H. Plimpton, M.D., Emeritus President of the American University of Beirut and a Presbyterian alumnus, spoke on "Borborygmi in Beirut," a metaphor borrowed from medicine (borborygmi means stomach rumblings) to describe the political unrest that has plagued Beirut over the past decade. ■

## PH a Partner in AIDS Research Center

The National Institute of Mental Health has awarded its largest single grant, \$13.6 million (in direct costs), to the New York State Psychiatric Institute to develop an AIDS research center. The Presbyterian Hospital will provide medical and social work services for patients enrolled in the research program at CPMC.

New York State has the highest number of AIDS patients in the country, with 12,427 cases reported as of mid-November. The center, to be called the HIV Center for Human and Behavioral Studies, will be one of only three in the country and the only one of its kind in the Northeast. It will focus on high-risk groups: adolescents, drug abusers, gay men and infants born to HIV-infected mothers.

Herbert Pardes, M.D., Director and Chairman of Psychiatry and Director of Psychiatric Institute, will chair the senior advisory council to the center. The effort is broad-based, involving scientists and clinicians at PH, St. Luke's-Roosevelt, Harlem Hospital and Psychiatric Institute, along with representatives of NIMH

and the New York City Health Department.

Principal investigators are Anke A. Ehrhardt, Ph.D., Professor of Clinical Psychology in the Department of Psychiatry and a senior research scientist in the Department of Child Psychiatry; Zena Stein, M.D., an internationally known epidemiologist at Columbia University School of Public Health and P.I.; and Robert L. Spitzer, M.D., Professor of Psychiatry and Director of Biometrics at P.I.

Other PH participants include Harold Neu, M.D., Attending Physician and Professor of Medicine and Pharmacology, and Jay Dobkin, M.D., serving on the medical core; and Rafael Tavares, M.D., Assistant Attending Psychiatrist and Assistant Clinical Professor of Psychiatry, Esther Chachkes, Director of Social Work Services, and Ralph Andrew, Director of Grants Development, serving on the community core.

The center will include studies of the psychiatric aspects of all stages of infection with human immunodeficiency virus (HIV), from high-risk behavior leading to infection, to neurological manifestations of the illness. ■



Joseph P. Corcoran, Executive Vice President for Administrative Affairs and Chief Operating Officer of the Hospital (far left), watching Dr. Plimpton (second from right) introduce Frederick O. Bowman, Jr., M.D., PH Attending Surgeon, to Cynthia J. Mackay, M.D., Assisting Ophthalmologist at PH.



J. Lawrence Pool, M.D., Consultant Emeritus in Neurological Surgery (center), with Richard B. Duane, Jr., M.D., President. PH Alumni Society and Mrs. Pool.



## Philanthropists Honored at 1987 Founders Day

The annual CPMC Founders Day celebrations, established in 1986 to recognize outstanding philanthropy for the Medical Center, honored Florence and Herbert Irving, who were awarded Harkness Medallions in October for their commitment to clinical research at the CPMC.

The day's festivities also included the ceremonial laying of the Allen Pavilion cornerstone. Herbert Allen, who, with his brother, Charles, Jr., received a medallion last year, was introduced to the gathering. The Pavilion is named for the Allens' parents.

The largest proportion of the Irvings' endowment will help establish a professorship and several assistant professorships for young clinical researchers.

Since 1975, CPMC has had a clinical research

center, comprising 14 beds, an outpatient unit and lab facilities. The unit will be reconstructed as part of the PH Modernization Program and renamed the Herbert and Florence Irving Center for Clinical Research.

"It is often difficult for promising young physician-scientists to obtain support while at the same time trying to establish themselves and devote their main efforts to research," said Dr. Thomas Q. Morris. "Yet it is to these young investigators that we must look for the future of clinical advances in medicine."

Henrik Bendixen, M.D., Vice President for Columbia University Health Sciences and Dean of the Faculty of Medicine, said, "Through the generosity and foresight of Herbert and Florence Irving, the center has the potential for providing the impetus for significant improvements in patient care and the understanding of human disease." ■

## Program to Reduce High Cesarean Rate

A joint effort of New York State health officials and the American College of Obstetricians and Gynecologists has been formed to try to reduce the number of cesarean deliveries in the state. Heading the task force formed to address this issue is Mortimer Rosen, M.D., Director and Chairman of Obstetrics and Gynecology at CPMC.

Dr. David Axelrod, State Health Commissioner, said that one of every four babies in New York State is delivered by cesarean section. That ratio reflects the national rate of about 25 percent, but state health officials want to reduce the rate by

between 12 and 14 percent, which they say more accurately reflects the number of women who truly require the surgery.

Dr. Rosen, who led the NIH Consensus Conference in 1980, which first raised the issue of high C-section rates to national prominence, has created a mechanism at Presbyterian whereby every cesarean birth is subjected to clinical review. In a *New York Times* article announcing the joint effort, it was noted that a similar review process instituted in many hospitals for such procedures as hysterectomies resulted in improvement in quality of care in those patients.

Dr. Rosen says that the issue is not to change a number, but rather to improve patient care. ■

## Cholesterol Guidelines Set For Adults

DeWitt S. Goodman, M.D., Attending Physician at Presbyterian and Tilden-Weger-Bieler Professor of Preventative Medicine at P&S, chaired a panel of physicians and scientists assembled by the National Heart, Lung and Blood Institute of the National Institutes of Health, which has established guidelines for physicians on monitoring and treating patients' cholesterol levels.

The panel was formed in response to a 1986 NHLBI study that showed that one-half to three-quarters of physicians did not provide diet or drug treatment for patients with dangerously high cholesterol levels.

First, the panel called for all Americans over age 20 to have their cholesterol levels checked. Second, the experts established the first well-defined cholesterol-level standards for adults and spelled out precisely what physicians should do once a patient's cholesterol level is determined.

The report delineates

three cholesterol ranges. Levels below 200 mg/dl (milligrams per deciliter of serum) are considered desirable. Those with readings from 200 to 239 mg/dl are classified as having borderline-to-high levels and advised to watch their diet and be retested annually.

Individuals with levels of 240 mg/dl and up have high blood cholesterol and require further medical attention. Patients with high-risk levels of LDL-cholesterol and those with borderline-to-high-risk levels who have definite coronary heart disease or additional risk factors, should be started on cholesterol-lowering medical therapy.

The other major risk factors include: being male, having a family history of premature coronary heart disease, hypertension, cigarette smoking, diabetes, low HDL and severe obesity.

Diet is the primary approach to the treatment of high cholesterol levels. The guidelines do not apply to children. A second national panel, to be convened next year, will set standards for children. ■

## Planned Giving Is Creative Giving

If you are thinking of making a contribution to The Presbyterian Hospital this year, you might want to consider the many options afforded by a planned gift. Planned giving can help you further your own financial objectives while providing the satisfaction of seeing your donation at work.

"Planned giving makes it possible for a donor to give more than he or she might have thought possible, while at the same time it meets the donor's financial needs," says Judith S.

Hozore, Director of Planned Giving, CPMC Fund, Inc.

A few examples of planned gifts are the pooled income fund, charitable remainder annuity trust and the charitable remainder unitrust. Each takes full advantage of current tax laws and allows the donor to receive an income, while benefitting programs at CPMC. Gifts may be in the form of securities or real property, as well as cash.

For further information, please contact Judith S. Hozore, Esq., CPMC Fund, Inc., 100 Haven Avenue, New York, NY 10032; 212-781-2100. ■



# BABIES HOSPITAL WELCOMES ITS NEW ADDITION

BABIES HOSPITAL HAS A NEW addition: an \$18.8 million, four-story addition with fully modern operating rooms, imaging equipment, such as scanners, ultrasonography and X-rays for children and amenities to provide a comfortable and supportive environment for patients and their families. The fourth floor operating rooms opened in October, and the third floor pediatric radiology suite began to be phased in in December.

"It has always been our goal to provide the ambience of a pediatric facility for all children requiring surgery," says R. Peter Altman, M.D., Director of Pediatric Surgery at PH and Schullinger Professor of Pediatric Surgery at P&S. "With the completion of the new operating room facility this is now a reality."

All children's surgery will be performed in the new Babies Hospital surgical suite, comprising six large, fully equipped operating rooms designed to support all procedures,

from the more common to the most highly technological and demanding. For the first time, all complex specialty cases will be performed in the Babies operating rooms.

The unit's waiting rooms are large and bright, and are designed specifically to provide an atmosphere of warmth and comfort for children and families. For children having day surgery, families can go to a cheerful playroom where a Child Life specialist talks with them to minimize anxieties and to comfort and educate them. When it is time to enter the OR, one parent may accompany the patient and stay there until the child is asleep.

When the operation is over, the parents are reunited with their child in the adjacent recovery room. After becoming stable, the child is taken with the parents to a step-down recovery area where fruit juice and light snacks are provided. The family remains here for an hour or so, until the child is ready to go home.

Children who are inpatients return to their hospital rooms.

"The best part of the new addition is that now we genuinely can provide family-centered care," says Leslie Schmidt, R.N., Nursing Care Clinician in the recovery room. "We can minimize the trauma of separation and maximize the time families can spend with the patient."

On the third floor, the most advanced radiology equipment has been installed to provide sophisticated diagnostic imaging procedures for pediatric patients. The added space doubles the current area. The new computed tomography (CT) scanner in Babies will eliminate the need for transporting children who require neurological CT scanning.

"The Babies Hospital addition brings efficient, centralized services to pediatric patients and enables us to meet their needs in an environment specifically designed with children in mind," Dr. Altman says. ■

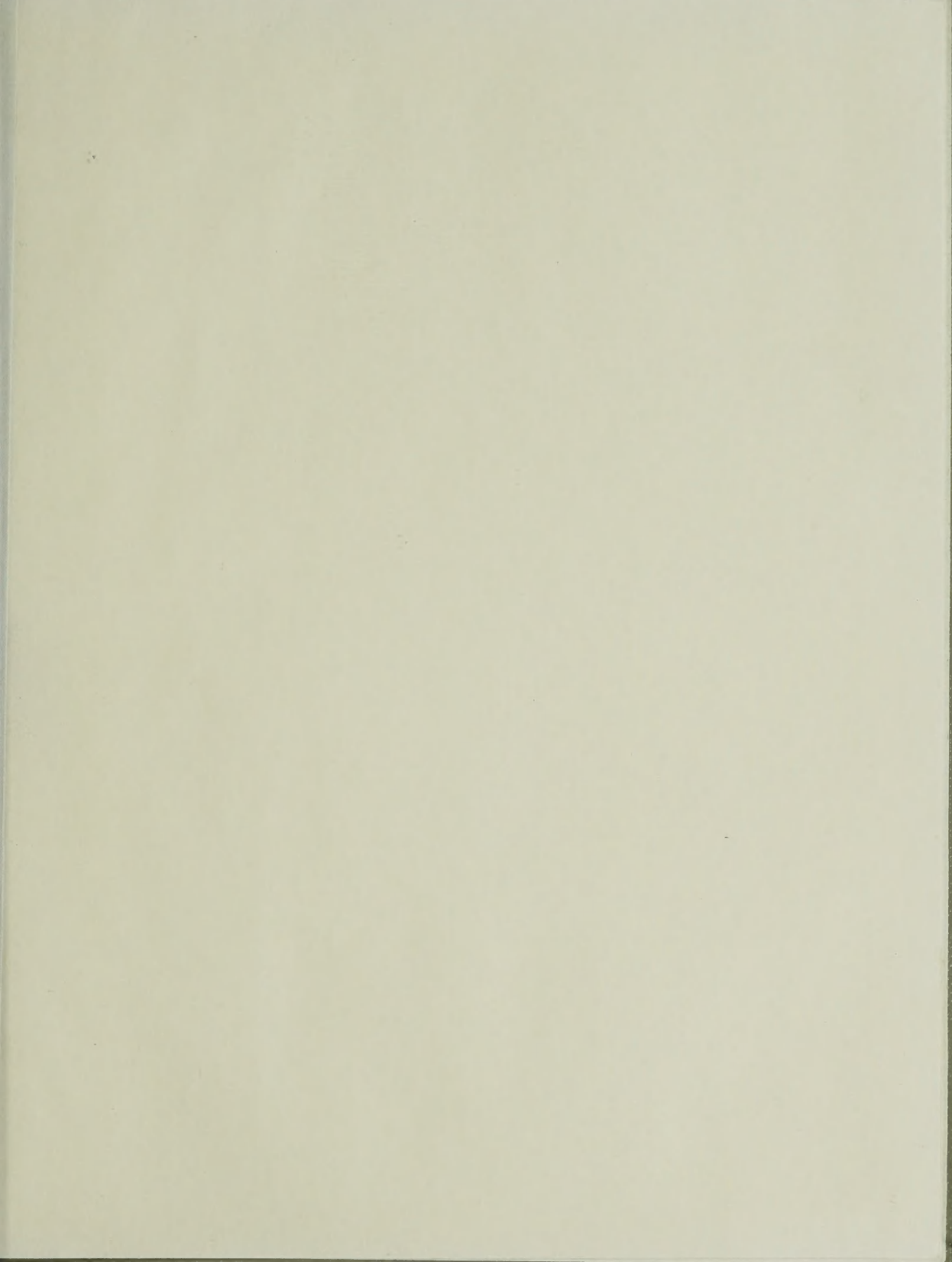




**The Presbyterian Hospital**  
Columbia-Presbyterian Medical Center  
New York, NY 10032-3784

Babies Hospital was the nation's first institution to treat sick infants.









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